ATTENTION ALL EMPLOYEES

MOUNT VERNON CSD

Workers' Compensation Medical Treatment

EFFECTIVE: Immediately

If you are injured at work, you must immediately report the incident to your supervisor.

Mount Vernon CSD has designated the following medical clinic to treat all workplace related injuries/illnesses.

If you need medical treatment due to a work-related injury or illness, seek treatment at:

UNITYPOINT CLINIC FAMILY MEDICINE
200 VIRGIL AVE SE
MOUNT VERNON, IA 52314
PH: (319) 895-8841

EMERGENCY CARE

For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility.

PLEASE NOTE

If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers' compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with your state's Workers' Compensation statute.

If you have any questions regarding this procedure, please call Matt Burke at (319) 895-8845.

Poster – Updated May 2017
Post in highly visible locations

EMC Insurance Companies

SUPERVISOR'S INSTRUCTIONS

ASSISTING THE INJURED EMPLOYEE

1. An employee who is injured at work must immediately report the incident to their supervisor.

2. Obtain immediate medical attention for the injured worker.

3. The local Unity Point Clinic is the district's designated medical treatment clinic for our employee's injuries. Most injuries can be treated at the local Unity Point clinic. For serious injuries or for any treatment that should not wait until the clinic hours the next day, seek immediate treatment from an emergency room. It is a good idea to call the medical facility (usually Unity Point 895-8841) prior to the employee's arrival to alert their staff to the injury and approximate arrival time.

4. The injured employee can complete the Employee's Work Injury Report form either before or after medical treatment.

5. Even if the employee does not want to seek medical treatment, both the Employee's Work Injury Report form and the Supervisor Investigation Report form must be completed so that the employee is covered by the district's insurance for any future necessary medical treatment caused by this injury. Completing these forms is always in the best interest of the employee.

6. If there is time before the employee goes for medical treatment, send with them a copy of the Physical Authorization Form for Medical Treatment and the form labeled Work Related Injury/Illness Report. But sending these forms with the employee is not required.

7. Email the superintendent and business manager that the injury has occurred.

8. Send to the district office the completed Employee's Work Injury Report form and the Supervisor's Investigation Report form within 24 hours of the injury so that the district office can file the report with the insurance company timely and meet the statutory filing requirements for the employee to be covered by the school insurance policy.

9. The district office will complete the official form for the Iowa Worker's Compensation – FIRST REPORT OF INJURY OR ILLNESS and send it to Mount Vernon Insurance for all injuries even if the employee did not seek medical treatment.

Employee's Work Injury Report

The injured employee is responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury.

Personal

Name _____

Address _____

City, State _____ Zip _____ Telephone _____

Married ☐ Single ☐ Number of Dependents _____ Home/School _____

Family Physician _____ Telephone Number _____

Are you currently entitled to Medicare Benefits? Yes ☐ No ☐ Medicare #(HICN) _____

Have you applied for Medicare or SSDI? Yes ☐ No ☐ Pending ☐ Rejected ☐

Employment

Job Title _____

Hours Worked Per Day _____

Time Work Day Begins _____

Injury/Illness

Date of Injury _____ Time of Accident _____

Where in the facility/job site did this injury occur? _____

What were you doing when injured? _____

How did the injury occur? _____

Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.)

_____

Any previous similar injury? If yes, explain. _____

Was this injury witnessed? If so, by whom? _____

Did you lose time from work? Yes ☐ No ☐ Date(s) missed _____

Have you returned? Yes ☐ No ☐ If yes, what was the date? _____

Treatment

Medical Facility _____

Diagnosis/Care Prescribed _____

Contact

When you return to work, you must call Matt Burke at (319) 895-8845 and notify your assigned claims adjuster.

Employee's Signature (PRINTED) _____ Date _____

Employee's Signature _____

EMC Insurance Companies

SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee:	Date:
Job Title and Department:	
Date and Time Of Injury:	Type of Injury:
Medical Treatment Center:	

What was the employee doing when injured? Where in the facility / job site did the accident happen?

Describe what happened:

What corrective steps will be done (or could be done) to prevent recurrence?

Was the employee working at designated job? ☐ Yes ☐ No

Is there modified duty available for the injured worker? ☐ Yes ☐ No

Has the injured employee returned to work? ☐ Yes ☐ No If so, what date?

Supervisor's Signature Date

Reviewed by Workers' Compensation Coordinator Date

Comments:

Return completed form within 24 hours of the accident to Matt Burke

EMC Insurance Companies

PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

Injured Employee's Name:	Date:
Company Name & Address: MOUNT VERNON CSD POLICY # 9X43613 525 PALISADES RD SW MOUNT VERNON, IA 52314	Supervisor:
Do Not Use Your Group Health Membership Card if this injury/illness was sustained while working or acting in an official capacity for this company.	

The following facility is the designated workers' compensation treatment center. Taking this Physician's Authorization Form with you will assist the staff in your care and in processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know you are on your way for medical treatment and the nature of the illness or injury.

UNITYPOINT CLINIC FAMILY MEDICINE
200 VIRGIL AVE SE
MOUNT VERNON, IA 52314
PH: (319) 895-8841

EMERGENCY CARE: *For a SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility.*

Send all EMC work comp medical bills directly to:
EMC Insurance Companies, P.O. Box 884, Des Moines, IA 50306 Fax: 888.992.8214

PLEASE NOTE

If you choose to be treated by any other medical facility and/or physician, you may not qualify for any workers' compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with your state's Workers' Compensation statute.

If you have any questions, please call Matt Burke at (319) 895-8845.

Supervisor's Signature _____ Date _____

Injured employee should take completed form to initial physician's visit

EMC Insurance Companies

Work Related Injury/Illness Report

Date of Service: _____

Patient Name: _____

Employer: MOUNT VERNON CSD

PLEASE FAX IMMEDIATELY TO BOTH:

Mount Vernon CSD Fax: (319) 895-8875

EMC Insurance WC Claims Fax: (888) 992-8214

Notified: ☐ Yes ☐ No

Diagnosis: Is condition work related? ☐ Yes ☐ No

Treatment Plan:

Medication(s): _____

Date of most recent examination by this office: __/__/____. The next scheduled visit is: ☐ as needed OR __/__/____.
Month/Day/Year Month/Day/Year

1. ☐ Recommended his/her return to work with no limitations on _____.
Date

2. ☐ He/She may return to work on _____ with the following limitations.
Date

DEGREE

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Very Heavy Work.** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

LIMITATIONS

1. In an 8 hour work day, patient may:

a. Stand/Walk	☐ None	☐ 4-6 Hours	
	☐ 1-4 Hours	☐ 6-8 Hours	
b. Sit	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours
c. Drive	☐ 1-3 Hours	☐ 3-5 Hours	☐ 5-8 Hours

2. Patient may use hands for repetitive:
   - ☐ Single Grasping
   - ☐ Pushing & Pulling
   - ☐ Fine Manipulation

3. Patient may use feet for repetitive movement as in operating foot controls: ☐ Yes ☐ No

4. Patient is able to:

	Frequently	Occasionally	Not at all
a. Bend	☐	☐	☐
b. Squat	☐	☐	☐
c. Climb	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS: _____

3. ☐ These restrictions are in effect until _____ or until patient is reevaluated.
Date

4. ☐ He/She is totally incapacitated at this time. Patient will be reevaluated on _____.
Date

Treating Facility Name: _____
Please Print

Physician's Signature: _____ Phone No: (___) _____

RELEASE OF INFORMATION AUTHORIZATION

I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.

Employee's Signature: _____ Date: _____

EMC Insurance Companies