

Non-SEMA4 Employee Details Data Form



Instructions: This form supplements the Injury, Illness, Incident Data Form and is for the collection and reporting of data associated with a work-related, injury, illness or incidents involving employees, volunteers, or student workers that do not have a SEMA4 employment record and work for organizations covered by Risk Management Division's Workers' Compensation Program. Agency Workers' Compensation Coordinators must complete this entire form and submit it either by email (preferred method) or signed paper copy to the Workers' Compensation Program via john.sargent@state.mn.us or johnathan.carver@state.mn.us or by fax at 651-297-5471. **Do not email directly from web site. Save completed form to your computer, then email.** Please note: this form must accompany the completed Injury, Illness, Incident Data Form (IDF) Other required forms are available at <http://www.admin.state.mn.us/risk/wc/wcforms.html>

Employee Details

1. First name of injured person:		2. Middle initial:		3. Last name:		4. Incident date: (MM/DD/YY)		5. Hire date: (MM/DD/YY)	
6. Current mailing address House number:			7. Street name:			8. City:		9. State	10. Zip code
11. Social security #:			12. Date of Birth:		13. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		14. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Unmarried		
15. Occupation:		16. Occupation code:		17. Employment status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Volunteer <input type="checkbox"/> Other <input type="checkbox"/> Intermittent <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary					
18 Work shift wk 1 (eg M-F 8:00am-4:30pm):			19. Pay per hour:		20. Hours per day:		21. Days per week:		22. Average weekly wage:
Work shift wk 2 (eg M-F 8:00am-4:30pm):			23. Base salary:			24. Weekly meals:		25. Weekly lodging:	

Person completing this form

26. Name:		27. Work phone: ()	28. Signature:		29. Date:
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Insurer: Minnesota Dept. of Administration, Risk Management Division, Workers' Compensation Program P.O. Box 64081, St. Paul, MN 55164-0081 Phone (651) 201-3000		For agency use: Claimant Name _____ Date of Incident: _____ WC Claim #: _____	
Non-SEMA4 Employee Details Data Form rev. 3/1/09			

Supervisor's Injury/Illness/Incident reporting & Workers' Compensation Checklist



The following checklist outlines steps that supervisors should take to document incidents and/or a potential work-related injury or illness for purposes of workers' compensation. Further information regarding the reporting of work related injuries or the workers' compensation process can be found in the Supervisor's Workers' Compensation Handbook available online at:

<http://www.risk-workerscomp.admin.state.mn.us/pdf/WorkersCompAgencyHandbook2008.pdf>

Please note:

- In the event of a medical emergency, call 911 or follow your agency's emergency medical response procedures.
- Work related injuries may require regulatory reporting. Notify your agency's Workers' Compensation Coordinator (WC Coordinator) ***as soon as possible*** of any serious, life threatening, or fatal injuries or events that result in multiple hospitalizations. Not reporting within the required time periods may result in monetary penalties. If you do not know your agency WC Coordinator, please contact your agency Human Resources office.
- If you are reporting an event that does not include a reported injury or illness, please only complete items 1 through 4.
- All forms and information are available online at:
<http://www.risk-workerscomp.admin.state.mn.us/forms.htm>

Immediate Actions

Item	Action
___ 1.	Provide employee with a copy of the <i>Workers' Compensation Information and Privacy Statement</i> form and ask them to review and sign the statement. Supervisor to forward signed form to WC Coordinator.
___ 2.	Provide employee with <i>Employee Statement regarding injury/illness/incident</i> form with instructions to complete the statement as soon as possible but no later than 24 hours. Completed form should be returned to supervisor who will forward to WC Coordinator.
___ 3.	Complete <i>Incident/Injury/Illness Data Form</i> (IDF, this form replaces the First Report of Injury or FRI) with employee and submit to WC Coordinator as soon as possible but no later than 24 hours.
___ 4.	Complete <i>Agency Claims Investigation</i> and submit to WC Coordinator as soon as possible but no later than 24 hours.
___ 5.	Complete <i>Leave Supplement Form</i> and submit to WC Coordinator as soon as possible but no later than 24 hours.
___ 6.	Provide employee with <i>Workers' Compensation Employee Information Packet</i> . Review the documents with the employee to ensure a clear understanding of the process. The Workers' Comp Employee Information Packet includes the following documents: <ul style="list-style-type: none"><input type="checkbox"/> <i>Employee Information Packet</i> introduction<input type="checkbox"/> <i>Notice of Enrollment in a Certified Managed Care Plan</i><input type="checkbox"/> <i>CorVel Managed Care Plan Instruction Brochure</i><input type="checkbox"/> <i>CorVel Managed Care ID Card</i><input type="checkbox"/> <i>CorCareRX Pharmacy Benefit</i><input type="checkbox"/> <i>Report of Work Ability</i> form
___ 7.	Provide employee with temporary CorVel RX First Fill pharmacy card to be taken to first medical

Supervisor's Injury/Illness/Incident reporting & Workers' Compensation Checklist



appointment. **Please note:** your work location might not participate in the First Fill program. Please contact your WC Coordinator for further information.

- ___ 8. Direct employee to employer's designated clinic. If you are unsure of the designated clinic please refer to your workplace employment postings or contact your WC Coordinator.
- ___ 9. Inform your agency WC Coordinator if an employee seeks medical attention for a potential work-related injury or illness or is expected to miss work (including the use of sick or vacation leave) due to the injury or illness.
- ___ 10. Contact CorVel's 24 hour Nurseline (the state's managed care organization) at 612-436-2542 or 1-866-399-8541 if the injured employee is treated in an emergency room, is admitted to an overnight stay at a hospital or requires immediate surgery.
- ___ 11. Document all witness statements and contact information, specifically name and phone number.
- ___ 12. Secure and isolate any equipment that may have contributed to the injury. The equipment may be evaluated for potential recovery claims.
- ___ 13. For motor vehicle crashes only - provide employee with ***Department of Public Safety Crash Records Request Form*** and directions to complete the form. Supervisor should forward completed form to WC Coordinator.

Ongoing actions until employee has fully returned to work:

- ___ 14. Obtain a copy of the ***Work Ability Report*** from the injured employee **for each appointment** and forward to WC Coordinator.
- ___ 15. If the employee doesn't seek medical attention initially, but does so at a later time, notify your workers' compensation coordinator immediately.
- ___ 16. Provide employee with ongoing task assignments within restrictions identified in most current ***Work Ability Report***.
- ___ 17. Review employee timesheets to ensure that they accurately indicate any lost time due to the potential work-related injury or illness, noting specifically what the lost time was attributed to (e.g. doctor's appointment, physical therapy, restricted work activity, etc.)

Workers' Compensation Program Information and Privacy Statement



The Minnesota Government Data Practices Act (MN Statutes, Chapter 13) requires that you be informed of the following:

1. The data your agency or the Department of Administration collects from you, for the First Report of Injury, or during the course of investigating or managing your claim, is private data and will be collected for the purpose of assisting Admin in making an initial determination of whether your injury is work related; in determining any initial and continued eligibility to receive benefits; and in computing the amount of payment you may be entitled to receive, should it be determined that your injury is work related. The data is also collected for the purpose of reporting to the Department of Labor and Industry any injury which wholly or partly incapacitates an employee from performing labor or services for more than three calendar days. This report is required by law.
2. You are NOT legally required to provide this information to us. However, if you do not provide certain data to us, we may be unable to complete the investigation of your claim for benefits and determine eligibility for benefits. Your refusal to provide information may cause your claim to be denied, or if you are eligible for benefits, your payment may be delayed. If you provide data to us, it will assist us in making an appropriate determination of liability and benefit eligibility.
3. The information you provide will be available to:
 - those within your agency and the Department of Administration whose jobs reasonably require access, such as workers' compensation coordinators or claims management specialists;
 - your medical provider(s);
 - the state's managed care vendor, and other vendors providing services for Admin
 - the Workers' Compensation Reinsurance Association;
 - The Minnesota Department of Labor and Industry;
 - The Office of Administrative Hearings, Legislative Auditor, Attorney General's Office, Social Security Administration, applicable state retirement system, enforcement agencies with statutory authority to obtain the data, and any other person or entity authorized by law or court order.
4. You may review all non-investigative claim information maintained by the Department of Administration, Workers' Compensation Program. There is no charge for reviewing this information; however, there is a small copy charge if you request copies.

I HAVE READ THE NOTICE REGARDING INFORMATION AND PRIVACY AS SET FORTH ABOVE.

Date

Signature

cc: Employee

Employee statement regarding injury/illness/incident



Instructions: This form is for the collection and reporting of data associated with a reported work-related injury, illness, or incident. Supervisors should have employees reporting a work-related injury, illness, or incident immediately complete this form (electronic document is preferred method, paper copy is acceptable). This completed document along with all other required injury, illness, or incident forms should be sent to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness, or incident.

1. First name:		2. Middle initial:		3. Last name:	
4. Emp/State ID #:	5. Work phone: ()	6. Home phone: ()	7. Date of incident:	8. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	
9. Where did the incident occur? <i>(Please be specific, indicate building, floor, location, street address, etc. Draw a map if necessary)</i>					
10. What were you doing when the incident occurred? <i>(Please indicate task being performed and include the activities immediately before incident)</i>					
11. Give a detailed description of how the injury/illness occurred. <i>(Please include details about the work environment and any items being used)</i>					
12. Describe the injury/illness and body part(s) affected. <i>(Please be specific, for example: I burned the tip of my index finger on the right hand.)</i>					
13. Who was present when the injury/illness occurred? <i>(Please include the full names of anyone present)</i>					
14. What changes do you suggest to prevent this from happening again?					
15. Employee Signature: <i>(if submitting electronically, please type name)</i>				16. Date:	

Insurer: Minnesota Dept. of Administration, Risk Management Division, Workers' Compensation Program P.O. Box 64081, St. Paul, MN 55164-0081 Phone (651) 201-3000	For office use: Claimant Name _____ Date of Incident: _____ WC Claim #: _____ SEMA4 Incident #: _____ WC Claim Specialist _____
Employee Statement rev. 2/1/09	

IDF - Injury, Illness, Incident Data Form (replaces First Report of Injury or FRI)



Instructions: This form is for the collection and reporting of data associated with a work-related, injury, illness or incident. Supervisors must complete this entire form and submit either by email (preferred method) or signed paper copy to the Agency Workers' Compensation Coordinator within 24 hours of receiving notice of the injury, illness or incident. Supervisors should immediately contact CorVel (the state's workers' compensation managed health care system) at 612-436-2542 or 1-866-399-8541, if an injured employee is admitted to an overnight stay at a hospital or requires immediate surgery on day of injury. **Please contact your agency/facility's Workers' Compensation Coordinator with any questions.** Checklists, forms, and instructions outlining supervisors responsibilities are available at: <http://www.risk-workerscomp.admin.state.mn.us/forms.htm>

Incident Details

1. Date of incident: (MM/DD/YY)	2. Time of incident: <input type="checkbox"/> am <input type="checkbox"/> pm	3. Date reported: (MM/DD/YY)	4. Incident type: <input type="checkbox"/> Incident <input type="checkbox"/> Injury – no lost time <input type="checkbox"/> Injury - lost time <input type="checkbox"/> Property damage
5. Description of incident: (limited to 250 characters, be sure to include detail about the body part, cause, and nature of injury) For example: "worker developed soreness in left wrist over time doing computer work" or "slipped and fell on wet floor breaking right leg"			6. Chemical, tools, equipment, or items involved: (e.g. "boxes")
			7. Specific body part:
8. Employer/Agency:	9. Facility/Location:	10. Division:	11. Exact location of incident:
12. Incident reported to (full name):	13. Emp/State ID#:	14. Work phone: ()	15. Has incident investigation been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
16. Person reporting incident (full name):	17. Emp/State ID#:	18. Work phone: ()	19. Incident result in fatality? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter date:
20. Is there a witness to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Witness's full name (if more than one please attach separate page):		22. Witness's phone: ()
23. Did incident involve travel? <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Was a state vehicle damaged? <input type="checkbox"/> Yes <input type="checkbox"/> No	25. Motor vehicle accident report completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Injury/Illness Details

26. Injured person's employment status (If contract worker please stop here) <input type="checkbox"/> Employee <input type="checkbox"/> Volunteer <input type="checkbox"/> Student <input type="checkbox"/> Intern <input type="checkbox"/> Contract worker				
27. First name of injured person:	28. Middle initial:	29. Last name:		
30. Emp/State ID #:	31. Work phone: ()	32. Home phone: ()	33. Start time day of injury: <input type="checkbox"/> am <input type="checkbox"/> pm	
34. Work shift (e.g. M-F 8:00am-4:30pm):	35. Does employee have second job? <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Second employer name:	37. 2 nd job gross weekly income:	
38. Has injured employee missed work due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	39. First date employee missed work:	40. Date employee last at work:	41. Missed work on day of injury due to injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of hours:	
42. Date employer notified of lost time:	43. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		44. Date returned to work:	
45. Was medical treatment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	46. Emergency room visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		47. Hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
48. Medical facility's name: <i>(if no medical treatment please respond "None")</i>		49. Medical facility's address:		
50. Treating physician's name: <i>(if no medical treatment please respond "None")</i>		51. Physician's phone: ()	52. Treating physician's address:	

Supervisor/Designee Certification

53. Supervisor/Designee name:	54. Emp/State ID#:	55. Work phone: ()	56. Signature:	57. Date:
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Insurer: Minnesota Dept. of Administration, Risk Management Division, Workers' Compensation Program P.O. Box 64081, St. Paul, MN 55164-0081 Phone (651) 201-3000	For office use:	Claimant Name _____ Date entered into SEMA4: _____
		Date of Incident: _____ Entered by: _____
Injury/illness/incident Data Form rev. 2/1/09		WC Claim #: _____ SEMA4 Incident #: _____
		WC Claim Specialist _____
		Agency hire date: _____ WC Location Code: _____



Agency Claims Investigation

(SEMA4 panels are in italics)

Dept. of Administration
 Risk Management Division
 Workers' Compensation Program
 PO Box 64081
 St. Paul, MN 55164-0081
 (651) 201-3000
 FAX (651) 297-5471

Injured Employee's Name (Last, First, M.I.)	Agency Name
1.	4.
Date of Claimed Injury (DOI)	Agency Location
2.	5.
Employee Phone #	
3.	

Investigative Questions	6. Describe in detail the tasks, activities, and conditions leading up to the injury/illness. <i>(SEMA4 Panel, Inj Det-Statements EE State)</i>				
	7. Describe in detail how the injury/illness occurred. <i>(Inj Det-Statements ER State)</i>				
	8. Describe in detail the injury or illness. <i>(Inj Det-Description)</i>				
	Complete causal factor analysis on page 2 before proceeding to questions 9-12.				
	9. Provide a detailed description of all hazardous conditions, such as defective equipment, excessive noise, natural, or traffic hazards that may have contributed to this injury/illness. <i>(Consequent Actions-Correct/Prevent)</i>				
	<input type="text" value="Primary Hazard Condit Code:"/>				
	10. Provide a detailed description of all unsafe acts such as failure to use safety equipment, improper use of equipment, or unsafe posture that may have contributed to this injury/illness. <i>(Inj Det-Details)</i>				
	<input type="text" value="Primary Unsafe Act Code:"/>				
	11. Please describe immediate corrective actions you have taken to prevent additional injuries/illnesses. <i>(Consequent Actions-Corrective)</i>				
	12. Please describe all preventative actions you are taking to reduce or eliminate similar hazards in the future. <i>(Consequent Actions-Preventative)</i>				
	13. Name, title and phone number of individual completing this form. <i>(Inj Det-Role/Address)</i>				
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Name</td> <td style="width: 50%;">Phone</td> </tr> <tr> <td>Title</td> <td>Date of Investigation</td> </tr> </table>	Name	Phone	Title	Date of Investigation
	Name	Phone			
	Title	Date of Investigation			
14. Agency management review					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Name</td> <td style="width: 50%;">Title</td> </tr> </table>	Name	Title			
Name	Title				

Incident Causal Factor Analysis

Employee Name

DOI

Step 1. Review and check all hazardous conditions that may have contributed to the incident. (Circle primary hazardous condition to be used for reporting purposes and record code on line 9, page 1.) NEC-Not Elsewhere Classified UNS-Unspecified

Possible Hazardous Conditions

(Three digit number is for coding purposes)

- | | | |
|--|--|---|
| <input type="checkbox"/> Defect, unsuitable materials 001 | <input type="checkbox"/> Inadequate ventilation 240 | <input type="checkbox"/> Uninsulated (electrical) 550 |
| <input type="checkbox"/> Defect, dull 002 | <input type="checkbox"/> Insufficient work space 250 | <input type="checkbox"/> Uncovered connections (electrical) 560 |
| <input type="checkbox"/> Defect, improper construction 003 | <input type="checkbox"/> Improper illumination 260 | <input type="checkbox"/> Unshielded (radiation) 570 |
| <input type="checkbox"/> Defect, improper design 004 | <input type="checkbox"/> Environmental hazard, NEC 299 | <input type="checkbox"/> Inadequate shield (radiation) 580 |
| <input type="checkbox"/> Defect, rough 005 | <input type="checkbox"/> Hazardous methods/procedure, UNC 300 | <input type="checkbox"/> Unlabeled/inadequate label 590 |
| <input type="checkbox"/> Defect, sharp 006 | <input type="checkbox"/> Inherently haz. material/equipment 310 | <input type="checkbox"/> Inadequate guarding, NEC 599 |
| <input type="checkbox"/> Defect, slippery 007 | <input type="checkbox"/> Inherently haz. method/procedure 320 | <input type="checkbox"/> Outside work hazard, UNS 600 |
| <input type="checkbox"/> Defect, worn, cracked, broken 008 | <input type="checkbox"/> Inadequate/improper tools/equipment 330 | <input type="checkbox"/> Defective premises 610 |
| <input type="checkbox"/> Defect, other, NEC 009 | <input type="checkbox"/> Inadequate help with lifting 340 | <input type="checkbox"/> Defective material/equipment, others 620 |
| <input type="checkbox"/> Wet, slippery, spills 020 | <input type="checkbox"/> Improper assignment of personnel 350 | <input type="checkbox"/> Other property hazard 630 |
| <input type="checkbox"/> Dress/apparel hazard, UNS 100 | <input type="checkbox"/> Hazardous method/procedure, NEC 399 | <input type="checkbox"/> Natural hazard 640 |
| <input type="checkbox"/> Lack of personal protection equipment 110 | <input type="checkbox"/> Placement haz., material/equipment, UNC 400 | <input type="checkbox"/> Public hazards, UNS 700 |
| <input type="checkbox"/> Improper/inadequate clothing 113 | <input type="checkbox"/> Improperly piled 410 | <input type="checkbox"/> Public transportation hazards 710 |
| <input type="checkbox"/> Dress/apparel hazard, NEC 119 | <input type="checkbox"/> Improperly placed 420 | <input type="checkbox"/> Traffic hazard 720 |
| <input type="checkbox"/> Environmental hazard, UNS 200 | <input type="checkbox"/> Inadequately secured 430 | <input type="checkbox"/> Other public hazard 780 |
| <input type="checkbox"/> Excessive noise 205 | <input type="checkbox"/> Inadequately guarded, UNC 500 | <input type="checkbox"/> hazard not listed 980 |
| <input type="checkbox"/> Failure to place warning signs 208 | <input type="checkbox"/> Unguarded 510 | <input type="checkbox"/> hazard not listed |
| <input type="checkbox"/> Inadequate aisle, exits, etc. 210 | <input type="checkbox"/> Inadequately guarded 520 | <input type="checkbox"/> hazard not listed |
| <input type="checkbox"/> Inadequate clearance 220 | <input type="checkbox"/> Lack of shoring 530 | <input type="checkbox"/> hazard not listed |
| <input type="checkbox"/> Inadequate traffic control 230 | <input type="checkbox"/> Ungrounded (electrical) 540 | <input type="checkbox"/> hazard not listed |

Step 2. Review and check all unsafe acts that may have contributed to the incident. (Circle primary unsafe act to be used for reporting purposes and record code on line 10, page 1.)

Possible Unsafe Act

(Three digit number is for coding purposes)

- | | | |
|--|--|---|
| <input type="checkbox"/> Caulking, packing under pressure 051 | <input type="checkbox"/> Use of hand instead of tool 356 | <input type="checkbox"/> Exposure to moving material 558 |
| <input type="checkbox"/> Clean, oil, adjust moving equipment 052 | <input type="checkbox"/> Improper use of equipment, NEC 359 | <input type="checkbox"/> Unsafe posture/position, NEC 559 |
| <input type="checkbox"/> Weld, repair without clearance 056 | <input type="checkbox"/> Inattention to footing/surroundings 400 | <input type="checkbox"/> Driving errors, public road, UNS 600 |
| <input type="checkbox"/> Work on energized equipment 057 | <input type="checkbox"/> Make safety device inoperative 450 | <input type="checkbox"/> Too fast/slow 601 |
| <input type="checkbox"/> Unsupervised actions, NEC 059 | <input type="checkbox"/> Block, plug, tie safety device 452 | <input type="checkbox"/> Enter/leave on vehicle traffic side 602 |
| <input type="checkbox"/> No personal protection equipment used 100 | <input type="checkbox"/> Disconnect/remove safety device 453 | <input type="checkbox"/> Failure to signal turn, stop, backup 603 |
| <input type="checkbox"/> Unsafe personal attire 150 | <input type="checkbox"/> Misadjust safety device 454 | <input type="checkbox"/> Failure to yield right-of-way 604 |
| <input type="checkbox"/> Failure to secure/warn, UNC 200 | <input type="checkbox"/> Improper replacement of device 456 | <input type="checkbox"/> Following too closely 606 |
| <input type="checkbox"/> Fail to lock/block 201 | <input type="checkbox"/> Inoperative safety device, NEC 459 | <input type="checkbox"/> Improper passing 607 |
| <input type="checkbox"/> Fail to shut off equipment 202 | <input type="checkbox"/> Working at unsafe speed, UNC 500 | <input type="checkbox"/> Turn from wrong lane 608 |
| <input type="checkbox"/> Fail to place warning signs 203 | <input type="checkbox"/> Feed/supply to rapidly 502 | <input type="checkbox"/> Driving errors, public road, NEC 609 |
| <input type="checkbox"/> Start/stop equipment without warning 207 | <input type="checkbox"/> Jump from elevation 503 | <input type="checkbox"/> Unsafe placing, mix, combine, UNC 650 |
| <input type="checkbox"/> Fail to warn, NEC 209 | <input type="checkbox"/> Operate vehicle unsafe speed 505 | <input type="checkbox"/> Combining resulting in fire/exp. 653 |
| <input type="checkbox"/> Horseplay 250 | <input type="checkbox"/> Running 506 | <input type="checkbox"/> Unsafe placing of vehicle/equipment 655 |
| <input type="checkbox"/> Improper use of equipment, UNC 300 | <input type="checkbox"/> Throwing materials 508 | <input type="checkbox"/> Unsafe placement of tools, scrap 657 |
| <input type="checkbox"/> Equipment use improper manner 301 | <input type="checkbox"/> Unsafe speed, NEC 509 | <input type="checkbox"/> Unsafe placement, NEC 659 |
| <input type="checkbox"/> Overloading equipment 305 | <input type="checkbox"/> Unsafe posture/position, UNC 550 | <input type="checkbox"/> Use of unsafe equipment, UNS 750 |
| <input type="checkbox"/> Improper use of equipment, NEC 309 | <input type="checkbox"/> Confined space violations 552 | <input type="checkbox"/> Unsafe act not listed 900 |
| <input type="checkbox"/> Improper use of body parts, UNC 350 | <input type="checkbox"/> Ride in unsafe position 555 | <input type="checkbox"/> Unsafe act not listed |
| <input type="checkbox"/> Insecure grip 353 | <input type="checkbox"/> Exposure to suspended load 556 | <input type="checkbox"/> Unsafe act not listed |
| <input type="checkbox"/> Improper hold of object 355 | <input type="checkbox"/> Exposure to swinging load 557 | <input type="checkbox"/> Unsafe act not listed |

Step 3. Check all other contributing factors that may have contributed to the incident.

Other Contributing Factors

- | | | |
|--|--|---|
| <input type="checkbox"/> Lack of policy/procedures | <input type="checkbox"/> Insufficient sup training | <input type="checkbox"/> Inadeq workplace inspect |
| <input type="checkbox"/> Safety rules not enforced | <input type="checkbox"/> Improper maintenance | <input type="checkbox"/> Inadequate equipment |
| <input type="checkbox"/> Hazards not identified | <input type="checkbox"/> Inadequate supervision | <input type="checkbox"/> Unsafe design/construction |
| <input type="checkbox"/> PPE unavailable | <input type="checkbox"/> Inadequate job planning | <input type="checkbox"/> Unrealistic schedule |
| <input type="checkbox"/> Insufficient ee training | <input type="checkbox"/> Inadequate hiring | <input type="checkbox"/> Poor process design |

Step 4. Based on information above, consider possible corrective actions or measures to control immediate hazard.

Corrective Actions

- | | | |
|---|---|--|
| <input type="checkbox"/> Fix or repair | <input type="checkbox"/> Warning signs | <input type="checkbox"/> Install protective barriers |
| <input type="checkbox"/> Employee communication | <input type="checkbox"/> Utilize safety equipment | <input type="checkbox"/> Other |

Step 5. Based on information above, consider possible preventative actions to eliminate or permanently control hazards so injuries do not reoccur.

Preventative Actions

- | | | |
|--|---|--|
| <input type="checkbox"/> Fix or repair | <input type="checkbox"/> Warning signs | <input type="checkbox"/> Install protective barriers |
| <input type="checkbox"/> Employee communication | <input type="checkbox"/> Utilize safety equipment | <input type="checkbox"/> Conduct inspections |
| <input type="checkbox"/> Institute safety procedures | <input type="checkbox"/> Safety training | <input type="checkbox"/> Other |
| <input type="checkbox"/> Modify process/procedures | <input type="checkbox"/> Engineering controls | <input type="checkbox"/> Other |

Step 6. Complete questions 9-12 on page 1. Multiple corrective and preventative actions may be necessary to ensure control of the hazard(s) and to prevent future injuries.

Reporting Information

This form is to be completed by the employee's immediate supervisor, the agency's investigator, or designee and submitted in conjunction with the First Report of Injury. Complete this form in its entirety. The Agency Claims Investigation form will assist your agency in identifying the causal factors of workplace injuries/illnesses and the implementation of corrective actions while also helping the Department of Administration Workers' Compensation Program in determining the compensability of the reported work-related injury or illness and in identifying possible subrogation sources.

Please type or print legibly. If you need additional space when responding to any of the questions, you may add additional pages.

Form Instructions

- | | |
|--------------------|--|
| Items 1 through 5 | Same information as reported in the First Report of Injury form. |
| Item 6 | Describe in detail the task the employee was performing that lead to the injury/illness. This will assist you in identifying the causal factors of the injury/illness. |
| Item 7 | Based on your investigation, how did the injury/illness occur? Your description should include details of the circumstances and events that caused the injury/illness. |
| Item 8 | Describe in detail the employee's injury or illness. Your description should include all body parts (i.e., neck, cheek bone, left toe) affected and the extent of injury or illness (i.e., congestion, laceration, puncture or combination thereof). |
| Items 9 through 12 | Describe action(s) taken or to be taken to prevent this occurrence from happening again. See page 2, Incident Causal Factor Analysis, to complete these questions. |
| Item 13 | Name, title and phone number of the person conducting the investigation of the employee's claimed injury or illness and the date of the investigation. |
| Item 14 | The completed investigation should be reviewed and signed by agency management (such as the area, program, divisional manager of the employee injured). |
| Item 15 | Distribution - Submit this form to your agency's workers' compensation coordinator with the completed FRI. A copy of this form can be retained in the agency's workers' compensation file. |

Workers' Compensation Program Leave Supplement Form



As an employee of the State of Minnesota it is my understanding if I am receiving workers' compensation benefits that I have the option to supplement the workers' compensation benefits with accrued but unused sick leave, vacation or compensatory time. Sick leave must be exhausted before any other paid leave is used. It is also my understanding that by supplementing, leave accruals are based on the combined total of the number of hours paid by workers' compensation, the number of hours of sick and/or vacation leave used, compensatory time and/or regular hours worked.

It is my understanding that, if I am off work and my choice of leave supplementation is exhausted, accruals and supplementation in subsequent pay periods will cease.

It is my understanding that I may choose to change my option to supplement or not to supplement by completing this form each and every time a change is made.

If I choose not to supplement with sick leave, vacation leave and/or compensatory time, and I am unable to work, I must request to be placed on an unpaid medical leave and, therefore, I will be ineligible to accrue sick and vacation leave.

If I return to work at reduced hours and continue to supplement with accrued but unused sick and/or vacation leave, while receiving a partial workers' compensation benefit, it is my understanding that leave accruals are based on the combined total of the number of hours the workers' compensation benefit represents, the number of hours worked and the hours supplemented.

If I return to work at reduced hours and choose to supplement the workers' compensation benefit with accrued but unused sick and/or vacation leave, accruals are prorated based on the number of hours worked and the hours the workers' compensation benefit represents.

_____ I choose to supplement the workers' compensation benefit with accrued but unused sick leave _____ vacation leave _____ or compensatory time _____.

_____ I choose not to supplement the workers' compensation benefit with accrued, but unused sick leave, vacation leave or compensatory time.

_____ I choose to continue to supplement the workers' compensation benefit with accrued but unused sick leave, vacation leave or compensatory time while I am working at reduced hours.

_____ I choose not to supplement the workers' compensation benefits with accrued but unused sick leave, vacation leave or compensatory time while I am working at reduced hours.

Employee Name (please print)

Employee ID #

Date of Injury

Employee Signature

Date

REPORT OF WORK ABILITY

CorVel Corporation, 3001 NE Broadway St #600, Minneapolis MN 55413
Telephone (800)275-8893 or (612)436-2400 ~ Fax (612)436-2499

1. PATIENT INFORMATION		
Last Name	First	Middle Initial
Employee ID#	Date of Injury/Illness	
Job Title/Description	Home Phone	
Employer	Supervisor or Contact	Employer Phone
Work Comp Insurer	Claim Number	

2. AUTHORIZATION TO RELEASE INFORMATION	
I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.	
Patient Signature: _____	Date: _____

3. TREATING PROVIDER'S EVALUATION-COMplete IN FULL FOR EACH VISIT	
Treatment Date _____ / _____ / _____	For: <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Follow-up Appointment
	Nature of Visit: <input type="checkbox"/> Work Related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Unknown
Describe Circumstances of the Injury/Illness	
Diagnosis (include ICD-9 code)	
Treatment	
Medication (when ordering a medication, MN Rules require the words "Work Comp" or "W.C." be included on the prescription)	
Medication Prescribed Could Cause Drowsiness or Impair Ability to Drive and/or Operate Heavy Equipment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maximum Medical Improvement Reached (see instructions on the reverse side)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Date of MMI: _____	
Disability Permanency Rating (PPD) if applicable	
Referral/Consult	
Next Appointment	
Date: _____	Time: _____ Doctor: _____

4. RETURN TO WORK																																																													
<input type="checkbox"/> Employee is released from care and has no restrictions.																																																													
<input type="checkbox"/> May return to work with no restrictions: <input type="checkbox"/> Immediately, or <input type="checkbox"/> Beginning _____																																																													
<input type="checkbox"/> Injury will result in loss of time from work: from _____ through _____																																																													
<input type="checkbox"/> May return to work with the following restrictions: from _____ through _____ (note: schedule appointment)																																																													
Patient's capabilities:																																																													
Patient is able to lift up to: _____ lbs.																																																													
Patient is able to use Hands: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																																																													
Hand / Wrist / Elbow / Shoulder restrictions: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																																																													
In an 8 hour day patient may (in hours):																																																													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;">none</td> <td style="width: 10%;">1-2</td> <td style="width: 10%;">2-4</td> <td style="width: 10%;">4-6</td> <td style="width: 10%;">6-8</td> <td style="width: 10%;"></td> <td style="width: 10%;">none</td> <td style="width: 10%;">1-2</td> <td style="width: 10%;">2-4</td> <td style="width: 10%;">4-6</td> <td style="width: 10%;">6-8</td> </tr> <tr> <td style="text-align: right;">Stand and Walk</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td style="text-align: center;">Sit</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Bend and Squat</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td style="text-align: center;">Drive</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Carry and Level Lift</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td style="text-align: center;">Push / Pull</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Bend and Lift</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		none	1-2	2-4	4-6	6-8		none	1-2	2-4	4-6	6-8	Stand and Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend and Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carry and Level Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Push / Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend and Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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Bend and Lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																		
Other Restrictions: _____																																																													
Any Restriction Given Apply to Home and Leisure Activities																																																													
Estimated Return to Full Duty is: _____ / _____ / _____ (If unable to return on full duty date, patient should return to clinic)																																																													

5. TREATING PROVIDER	
Provider Name (please print)	Clinic Name
Provider Signature	Clinic Address

REPORT OF WORK ABILITY INSTRUCTIONS

CorVel Corporation, 3001 NE Broadway St #600, Minneapolis MN 55413

Telephone (800)275-8893 or (612)436-2400 ~ Fax (612)436-2499

INSTRUCTIONS:

This form is to be completed by the treating provider for the initial evaluation and for all follow-up visits and treatment relating to a work injury or illness. This information is required under Minnesota Workers' Compensation Rules, 5221. A "treating provider" may be a medical physician, an osteopath, a chiropractor, a podiatrist or a dentist.

1. PATIENT INFORMATION:

Patient information is to be completed by the medical secretary or nurse, in conjunction with the injured / ill employee or with the employer / supervisor.

Complete all requested information. In particular, be sure to complete information identifying the patient and injury: patient name and social security number, date of injury / illness, and employer.

2. AUTHORIZATION TO RELEASE INFORMATION

Obtain the patient's signature authorizing the release or exchange of medical records and information relating to the medical condition to the employer or employer representative. The patient's release is recommended, although not required for MN workers' compensation.

3. TREATING PROVIDER'S EVALUATION – COMPLETE IN FULL FOR EACH VISIT

Completed by the treating provider at the time of the visit. This section includes specific information based on the provider's most recent evaluation of the employee's signs, symptoms, physical and clinical findings, and functional status.

CorVel notification is required for referrals / consultations. Other services may require prior authorization or coordination with the CorVel managed care plan. Consult the CorVel provider policy and procedures manual for sections describing:

- CorVel Provider Education – for procedures used in working with the managed care plan.
- Workers' Compensation Medical Treatment Parameters – established by the Department of Labor and Industry.

Follow-up appointments should be assigned as medically necessary. In particular, follow-up appointments should be assigned:

- When the physician is unable to assess a full-duty date.
- When an employee has been seen by an Emergency Room contracting physician and the employee is unable to return to work within three (3) days. A follow-up visit is to be advised within three calendar days when it appears the disability will extend beyond the three day period.
- You must complete formal MMI information on the Health Care Report Form as required by the MN Department of Labor and Industry. Health Care Provider Report Forms are available from the MN Department of Labor & Industry.

4. RETURN TO WORK

Completed by the treating provider at the time of the visit. This section includes specific information regarding return to work instructions for the employee.

The return to work date shall be the earliest possible medically appropriate date, regardless of holidays, weekends, or regularly scheduled workdays.

Return to full duty shall be the date the employee can return to his or her normal duty job functions without restrictions.

Return to work with restrictions shall specifically indicate medical restrictions to be followed by the employee and employer.

A duration of these restrictions shall be assigned. Open-ended durations of disability or restriction may not be given.

5. TREATING PROVIDER

Completed by the treating provider at the time of the visit.

NOTICE TO EMPLOYEE

You must promptly provide a copy of this report to your employer or workers' compensation insurer, and to any assigned qualified rehabilitation consultant.

Workers' Compensation Program Employee Information Packet



The information included in this packet will become important to you in the event that you seek medical attention or lose time from work due to a work-related injury or illness. The following provides a brief description of the documents included in this packet and how they are to be used:

- ***Notice of Enrollment in a Certified Managed Care Plan*** – The State of Minnesota, Workers' Compensation Program uses a managed care organization, CorVel, to provide certified managed health care services.
- ***CorVel Managed Care Instruction Brochure*** - If you must seek medical attention due to a work-related injury or illness, please refer to the following brochure to determine which clinic you should go to. You should also bring this brochure with you to your doctor appointment.
- ***CorVel Managed Care ID Card*** – If you must seek medical attention due to a work related injury or illness please carry this card with you and provide it to your medical doctor's office when asked about insurance coverage.
- ***CorCareRX Pharmacy Benefit*** letter – The State of Minnesota, Workers' Compensation Program managed care organization, CorVel administers a workers' compensation prescription pharmacy program called CorCareRx for state employees with work-related injuries. This letter explains the program and what you can expect should your doctor prescribe medications related to your injury.
- ***Report of Work Ability*** form – If you must seek medical attention for your injury, this form should be taken with you to each appointment and should be completed by the treating physician. You will need to submit the form to your supervisor prior to your return to work after each appointment.

In the near future as your workers' compensation claim is processed, you will receive further information from the Workers' Compensation Claims Specialist assigned to your claim. Please watch for this letter in your mail. If you have any questions please contact your supervisor and/or agency Workers' Compensation Coordinator.

Notice of Enrollment in a Certified Managed Care Plan for Workers' Compensation Injuries and Illness

Please note a change in how necessary medical care will be provided to you in connection with your work injury. Under Minnesota Rule 5218.0250, the Minnesota Department of Administration provides this notice to inform you that:

Effective July 1, 2005, your employer (the State of Minnesota) enrolled with CorVel, a certified workers' compensation managed care plan that provides state employees and covered volunteers with all necessary medical treatment for work-related injuries and illness.

If injured in the course of your work, you may receive treatment from a medical doctor, chiropractor, podiatrist, osteopath, or dentist, if the treatment is available within the community and is appropriate for the injury or illness. You must receive all necessary medical treatment for your work injury from a health care provider who is a member of CorVel's plan, except in the following circumstances: you have already established a treating relationship with a non-participating provider (who maintains your medical records)* prior to the work-related injury; or if you require emergency treatment; or if your place of employment and residence are beyond the mileage parameters set forth in part 5218.0100, subp. 1.F.(7).

Furthermore, if you sustained your work-related injury prior to the State's enrollment with CorVel, you may continue to receive treatment from a non-participating provider until you change doctors.

You may access care for a work-related injury or illness by going to a clinic or health care provider from CorVel's network; or by asking your agency's Workers' Compensation Coordinator to share CorVel's provider directory with you; or by accessing CorVel's provider directory on-line at: <http://www.risk-workerscomp.admin.state.mn.us/index.htm> (Click on State Employee Information; then, click on the Workers' Compensation link where you can access the CorVel Provider Directory; or by calling CorVel's 24-hour Nurse Phone Line at 612-436-2542 or 866-399-8541. You may also contact CorVel's Nurse Phone line if you have questions about managed care for workers' compensation; or direct such inquiries to the State Workers' Compensation Program at (651) 201-3001. You may also contact your agency's Workers' Compensation Coordinator if you need assistance.

Additional information may be obtained by calling the Minnesota Department of Labor and Industry (DOLI) in St. Paul at (651) 284-5005 or (800) 342-5354. In Duluth, call DOLI at (218) 733-7810 or (800) 365-4584.

* In accordance with part 5218.0500, subparts 1 and 2, except that if you later change doctors you must then choose a doctor who participates in CorVel's plan.

Questions Or Concerns Regarding CorVel's Certified Managed Care Plan

CorVel will be happy to respond to questions about its Certified Managed Care Plan - please call:

612-436-2542 or 866-399-8541

You may also contact the Minnesota Department of Labor & Industry with questions at:

**800-342-5354 (St. Paul)
800-365-4584 (Duluth)**

CorVel welcomes feedback regarding its services. To voice a comment or concern about services you have received from CorVel's Certified Managed Care Plan, call the CorVel 24 hour information line at:

612-436-2542 or 866-399-8541

Formal Dispute Resolution Process Available To Employees

If you wish to file a dispute regarding services you have received from CorVel's Certified Managed Care Plan, please make a formal written request to initiate CorVel's Dispute Resolution Process to the attention of the Managed Care Manager at:

**CorVel Corporation
3001 NE Broadway Street, Suite 610
Minneapolis, MN 55413-2658**

Upon request, CorVel will make a formal written request on your behalf to initiate the dispute resolution process. This process will be completed within 30 days after your written request is received by CorVel's Managed Care Manager.

CorVel Does Not Determine Compensability

2/2008

7-1-2005

Effective Date

C O R V E L

**MINNESOTA CERTIFIED
MANAGED CARE PLAN
INSTRUCTION BROCHURE**

For the State of Minnesota



ATTENTION: ALL EMPLOYEES REGARDING WORK-RELATED INJURIES

Your employer has enrolled with CorVel, a Minnesota Certified Managed Care Plan, to provide all necessary medical management for workers' compensation injuries.

How To Obtain Medical Care Through CorVel Managed Care Plan

You are entitled to receive an initial evaluation from a participating medical provider within 24 hours of your initial request for medical care. If you live within the 7-county metro area, the provider must be geographically convenient and within a 30-mile radius of your workplace or residence. If you live in rural Minnesota, the provider must be geographically convenient and within a 50-mile radius of your workplace or residence. CorVel has a complete provider network which includes the following medical specialties: medical doctor; chiropractor; podiatrist; osteopath; or dentist. You may obtain medical care from a doctor within any of these specialties provided the treatment is available within your community and is appropriate for the injury or illness being reported.

24 HOUR INFORMATION LINE 612-436-2542 or 866-399-8541

CorVel has a 24 hour information line to assist in providing access to medical services under the Managed Care Plan and to address any questions or complaints regarding managed care services. The CorVel 24 hour information line is answered by CorVel staff during regular business hours (8 a.m. to 5 p.m., Monday through Friday, except holidays) and a nurse is available after hours. In addition, all employees may view a copy of the CorVel Provider Directory which is available via a link from the State of Minnesota website. Employees may also obtain information about access to providers by calling the 24 hour information line.

How to Obtain an Initial Appointment:

1. Prior to obtaining an appointment, report your injury to the person or department at your agency that has been designated to receive reports of work-related injuries. Upon reporting your injury, you will be provided with a Patient Identification Card and Managed Care Instruction Brochure.
2. Your employer has chosen a designated medical facility to provide you with an initial evaluating appointment within 24 hours of your request for care. See the Workplace Poster for your designated clinic's name and location.
3. Please present the Patient Identification Card to the medical provider when you begin treatment.

IF YOU ARE UNABLE TO OBTAIN AN INITIAL APPOINTMENT WITHIN 24 HOURS AT THE DESIGNATED FACILITY, CALL THE CORVEL 24 HOUR INFORMATION LINE

How to Obtain Emergency Medical Care or Urgently Needed Medical Services:

In the event of a medical emergency, seek treatment at the nearest medical facility **IMMEDIATELY**. Other urgently needed medical services may be obtained at the nearest available urgent care center. Emergency or urgently needed medical services may be obtained from any qualified provider regardless of participation in CorVel's Provider Network. Either you or your representative must call the **CorVel information line** within 48 hours of your initial emergency medical treatment. If you need additional medical care, CorVel will assist you in choosing an approved medical provider.

Medical Care Following Your Initial Appointment:

1. If you received an initial evaluation from your designated provider and you require treatment beyond your initial appointment, you may continue care with the same provider who performed your initial evaluation, as long as the required treatment is within this provider's scope of practice.
2. You also have the right to select a different treating provider following the initial evaluation. To obtain an appointment with a new provider, call the **CorVel 24 hour information line**.
3. If you received your initial evaluation under emergency conditions and the provider who performed your initial evaluation is not a member of the CorVel network and you wish to continue care with this provider, then the conditions outlined under ***Medical Care Outside Of The CorVel Provider Network*** must be met.

Medical Care Outside of CorVel's Regular Business Hours:

CorVel's regular business hours are 8 a.m. to 5 p.m., Monday through Friday, excluding holidays. If you require non-emergency medical care outside of regular business hours, you may obtain care through one of the following options:

1. Call the **CorVel 24 hour information line** and speak with the after hours nurse.
2. Seek care at the nearest available medical facility. Then call the CorVel information line within 48 hours. If you require further care, a member of CorVel's 24 hour information line staff will provide any necessary assistance in obtaining a medical appointment on your behalf.

How to Change Treating Providers:

If you are not satisfied with your medical treatment, you are allowed to change treating providers at least once. To change treating providers, call the **CorVel information line**.

Note: Selecting a different treating provider following the initial evaluation does not count as a change of treating provider **unless** you have seen the evaluating provider more than once for your current injury.

Medical Care Outside Of The CorVel Provider Network

If you have sustained a work-related injury **prior** to this notice, you may continue to receive treatment for that injury from a medical provider outside of the CorVel network until you decide to change doctors. Then you must change to a doctor within the CorVel network.

For work-related injuries occurring **after** this notice, you may seek medical treatment with a medical provider outside of the CorVel network in the following cases:

1. If you have established a history of treatment with a healthcare provider who maintains your medical records and you can document receiving medical care from this provider at least twice in the last two years. If your treatment history with a provider does not meet the standard (twice within the last two years), you must seek approval from CorVel or the workers' compensation insurer. The treatment for your work-related injury must also be within this provider's scope of practice.
 - ♦ You must provide CorVel with documentation of previous treatment within 10 days of notice to employer of an injury.
 - ♦ If you decide to change providers, it must be to a doctor within the CorVel network.
2. If the nearest provider available within the CorVel network is beyond the state mileage guidelines (30-mile radius in the 7-county Metro area and 50-mile radius in rural Minnesota) from your place of employment and residence.
3. If you require emergency or urgently needed medical services.

Managed Care ID Card Instructions:

1. Write the employee's first and last name in the space provided.
2. Write in the date of injury (DOI) in the space provided.
3. Cut out card along dotted lines.
4. Fold the card where indicated - the final card will be wallet-sized.
5. Employee should present this card at all health care provider visits for their work-related injury.

CorVel Corporation
Minnesota Certified Workers' Compensation Managed Care Plan

24 hour Employee Information Line
612-436-2542
866-399-8541

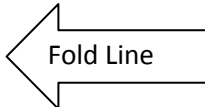
Send all Workers Compensation bills to CorVel at:
MedCheck-CorVel, Suite 610
3001 NE Broadway Street
Minneapolis, MN 55413-2658

CorVel Does Not Determine Compensability

Employee Name: _____
DOI: _____
Administrator: Dept. of Administration Work Comp. Program
Administrator Phone: 651-201-3000

Questions, Comments, Or Complaints Regarding CorVel's Certified Managed Care Services -
You can reach CorVel at 866-399-8541 or you may also contact the Minnesota Department of Labor & Industry at 800-342-5354 (St. Paul) or 800-365-4584 (Duluth).

Formal Dispute Resolution Process Available To Employees -
If you wish to file a dispute regarding services you have received from CorVel's Certified Managed Care Plan, please make a formal written request to the attention of the Managed Care Manager at: CorVel Corporation, 3001 NE Broadway Street, #610, Minneapolis, MN 55413-2658.

 Fold Line

Workers' Compensation Program CorCareRx Pharmacy Benefit



To: State Employee

Re: **Filling a prescription for your work injury with CorCareRx
First-Fill Temporary ID Cards &
CorCareRx ID Cards**

Please check with your agency workers' compensation coordinator to determine if your agency participates in the First-Fill Prescription ID cards. If your agency participates in the first-fill program, you should receive a CorCareRx First-Fill card from your agency that you should use to fill any initial prescription that a health care provider prescribes for your work-injury. This first-fill card can only be used one time.

Shortly you will receive a letter from CorVel with instructions on to how to fill workers' compensation-related prescriptions using CorCareRx, CorVel's workers' compensation pharmacy plan. The letter will include a personal identification card along with a list of pharmacies in the area where you may get your prescriptions filled. This ID card should be used for all workers' compensation-related prescriptions.

Once you receive the card, it is required that you use the card to fill prescriptions for your work injury. Use of the prescription card brings the following benefits:

- No out-of-pocket expense
- Eliminates the need for you to request reimbursement for the costs of prescriptions

The card can only be used for prescription medications related to the specific workers' compensation injury that the card is issued for. If you have questions upon receipt of the letter and card, call CorVel at (800) 275-8893.

The issuance of the card is tied to the timing of the submission of First Report of Injury forms and is automated. There is no call necessary to activate this benefit. Reimbursement requests for the cost of prescriptions filled prior to the issuance of the card may be sent to:

CorVel
Suite 610
3001 NE Broadway St.
Minneapolis, MN 55413-2658

REPORT OF WORK ABILITY

CorVel Corporation, 3001 NE Broadway St #600, Minneapolis MN 55413
 Telephone (800)275-8893 or (612)436-2400 ~ Fax (612)436-2499

1. PATIENT INFORMATION		
Last Name	First	Middle Initial
Employee ID#	Date of Injury/Illness	
Job Title/Description	Home Phone	
Employer	Supervisor or Contact	Employer Phone
Work Comp Insurer	Claim Number	

2. AUTHORIZATION TO RELEASE INFORMATION	
I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.	
Patient Signature: _____	Date: _____

3. TREATING PROVIDER'S EVALUATION-COMplete IN FULL FOR EACH VISIT	
Treatment Date _____ / _____ / _____	For: <input type="checkbox"/> Initial Treatment <input type="checkbox"/> Follow-up Appointment
	Nature of Visit: <input type="checkbox"/> Work Related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Unknown
Describe Circumstances of the Injury/Illness	
Diagnosis (include ICD-9 code)	
Treatment	
Medication (when ordering a medication, MN Rules require the words "Work Comp" or "W.C." be included on the prescription)	
Medication Prescribed Could Cause Drowsiness or Impair Ability to Drive and/or Operate Heavy Equipment <input type="checkbox"/> Yes <input type="checkbox"/> No	
Maximum Medical Improvement Reached (see instructions on the reverse side)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Date of MMI: _____	
Disability Permanency Rating (PPD) if applicable	
Referral/Consult	
Next Appointment	
Date: _____	Time: _____ Doctor: _____

4. RETURN TO WORK																																																													
<input type="checkbox"/> Employee is released from care and has no restrictions.																																																													
<input type="checkbox"/> May return to work with no restrictions: <input type="checkbox"/> Immediately, or <input type="checkbox"/> Beginning _____																																																													
<input type="checkbox"/> Injury will result in loss of time from work: from _____ through _____																																																													
<input type="checkbox"/> May return to work with the following restrictions: from _____ through _____ (note: schedule appointment)																																																													
Patient's capabilities:																																																													
Patient is able to lift up to: _____ lbs.																																																													
Patient is able to use Hands: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																																																													
Hand / Wrist / Elbow / Shoulder restrictions: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both																																																													
In an 8 hour day patient may (in hours):																																																													
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Other Restrictions: _____																																																													
Any Restriction Given Apply to Home and Leisure Activities																																																													
Estimated Return to Full Duty is: _____ / _____ / _____ (If unable to return on full duty date, patient should return to clinic)																																																													

5. TREATING PROVIDER	
Provider Name (please print)	Clinic Name
Provider Signature	Clinic Address

REPORT OF WORK ABILITY INSTRUCTIONS

CorVel Corporation, 3001 NE Broadway St #600, Minneapolis MN 55413

Telephone (800)275-8893 or (612)436-2400 ~ Fax (612)436-2499

INSTRUCTIONS:

This form is to be completed by the treating provider for the initial evaluation and for all follow-up visits and treatment relating to a work injury or illness. This information is required under Minnesota Workers' Compensation Rules, 5221. A "treating provider" may be a medical physician, an osteopath, a chiropractor, a podiatrist or a dentist.

1. PATIENT INFORMATION:

Patient information is to be completed by the medical secretary or nurse, in conjunction with the injured / ill employee or with the employer / supervisor.

Complete all requested information. In particular, be sure to complete information identifying the patient and injury: patient name and social security number, date of injury / illness, and employer.

2. AUTHORIZATION TO RELEASE INFORMATION

Obtain the patient's signature authorizing the release or exchange of medical records and information relating to the medical condition to the employer or employer representative. The patient's release is recommended, although not required for MN workers' compensation.

3. TREATING PROVIDER'S EVALUATION – COMPLETE IN FULL FOR EACH VISIT

Completed by the treating provider at the time of the visit. This section includes specific information based on the provider's most recent evaluation of the employee's signs, symptoms, physical and clinical findings, and functional status.

CorVel notification is required for referrals / consultations. Other services may require prior authorization or coordination with the CorVel managed care plan. Consult the CorVel provider policy and procedures manual for sections describing:

- CorVel Provider Education – for procedures used in working with the managed care plan.
- Workers' Compensation Medical Treatment Parameters – established by the Department of Labor and Industry.

Follow-up appointments should be assigned as medically necessary. In particular, follow-up appointments should be assigned:

- When the physician is unable to assess a full-duty date.
- When an employee has been seen by an Emergency Room contracting physician and the employee is unable to return to work within three (3) days. A follow-up visit is to be advised within three calendar days when it appears the disability will extend beyond the three day period.
- You must complete formal MMI information on the Health Care Report Form as required by the MN Department of Labor and Industry. Health Care Provider Report Forms are available from the MN Department of Labor & Industry.

4. RETURN TO WORK

Completed by the treating provider at the time of the visit. This section includes specific information regarding return to work instructions for the employee.

The return to work date shall be the earliest possible medically appropriate date, regardless of holidays, weekends, or regularly scheduled workdays.

Return to full duty shall be the date the employee can return to his or her normal duty job functions without restrictions.

Return to work with restrictions shall specifically indicate medical restrictions to be followed by the employee and employer.

A duration of these restrictions shall be assigned. Open-ended durations of disability or restriction may not be given.

5. TREATING PROVIDER

Completed by the treating provider at the time of the visit.

NOTICE TO EMPLOYEE

You must promptly provide a copy of this report to your employer or workers' compensation insurer, and to any assigned qualified rehabilitation consultant.