# Employee Injury and Illness Report

*To be Completed by Employee*

Case No. _____

Date of Injury ____/____/____ (month / day / year)

TO BE COMPLETED BY EMPLOYEE

| Social Security # | Name (Last) (First) (MI) | Sex (M or F) | Marital Status: r Married r Single r Divorced r Widowed |
|---|---|---|---|

| Home Address | City | State | Zip | Home # | Work # |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth ____/____/____ (month / day / year) | Age | Occupation | Department | Work Location and Title |
|---|---|---|---|---|
| | | | | |

| Work Status: r Full time r Part time — Hours per Day | # Days per week if part time | Immediate Supervisor |
|---|---|---|
| | | |

| Injured body part / areas *(indicate left or right if applicable)* | District building where accident occurred *(street, city, zip code)* |
|---|---|
| | |

| Time of Day injury or accident occurred: ____:____ AM or ____:____ PM | Date employer advised: ____/____/____ (month / day / year) |
|---|---|
| | |

Is this a recurrence of a previous injury or illness? r Yes r No If "YES" please give details _____

## Employee's Statement

*Please describe in detail how the injury occurred. Include what the situation was and any objects or tools involved:*

How did the accident occur? *(Explain how it happened)* _____

Was or will medical care be provided other than by school nurse? r Yes r No If yes, please complete the following:

| *Doctor's Name* | *School Nurse's Name* | *Emergency Room Location* |
|---|---|---|
| *Doctor's Address* | *School* | *Hospital* |

Were there any witnesses to the accident? r Yes r No If yes, please complete the following:

Witness Name: _____ Was the witness a District employee? r Yes r No Witness Phone #: _____

Witness Name: _____ Was the witness a District employee? r Yes r No Witness Phone #: _____

If witness is not a District employee, please provide name and address: _____

_____ *Employee Signature*

____/____/____ *Date*

***"Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self-insurer or purported insurer, or any agent thereof, any written statement as part of or in support of a claim for benefits containing any false, incomplete, or misleading information commits a fraudulent insurance act."***

# EMPLOYEE INJURY AND ILLNESS REPORT

**Employee Name**_____ **Date of Injury or Illness**____/____/____

***Supervisor's Investigation / Report:*** *This section must be completed by the supervisor prior to signing.*

TO BE COMPLETED BY SUPERVISOR

1. Cause Analysis: *Describe the factors contributing to this incident.*

2. Work Status: *Is the employee missing time from work:* r Yes r No r Don'tKnow

   *If Yes, how much time has employee missed?* _____

3. Recommended Corrective Actions: *What actions can / will be taken to prevent recurrence of this incident?*

_____ ____/____/____

*Supervisor's Signature* *Date*

## *Instructions*

- *The lead secretary/building designee is to file an electronic injury report with the District's Workers' Compensation TPA-PMA Management Corp. and provide a hard copy to the employee's supervisor for follow up, documentation, and signature.*
- *Page 2 of this report needs to be completed by the employee's immediate supervisor.*
- *The original completed form must be sent to Risk Management, Central Office.*
- *The supervisor is to follow up on the recommended corrective actions.*

***Claims can be reported at www.pmacompanies.com. Click on "Report a Claim". The user ID will be your account # and the password is "newclaim".***

PMA COMPANIES

# Schoharie Area WC Plan

## NOTIFICATION CONCERNING DIAGNOSTIC TESTING AND PRESCRIPTION DRUGS UNDER A WORKERS' COMPENSATION CLAIM

PMA has entered in an agreement with certain diagnostic networks to make available tests such as MRI, CT Scan and X-Ray to injured workers for their work-related injury or sickness. This does not change your right to get the testing, if ordered by a physician, and if the testing is related to the work injury. It only means that you must undergo such tests with a provider or at a facility that is affiliated with the networks listed below. These networks and their contact information, are:

| One Call Care | MedFocus Radiology Network | Genex Services |
|---|---|---|
| 800-872-2875 | 800-398-8999 | 800-310-3926 |

PMA also has an agreement with Express Scripts for all work related prescription drugs. A prescription card will be sent via USPS mail. If a prescription needs to be filled prior to receiving the prescription card, please have the pharmacy contact:

**EXPRESS SCRIPTS**
**800-945-5951**

The following address should be used for all correspondence and provided to medical providers:

**PMA Customer Service Center**
**P.O. Box 5231**
**Janesville, WI 53547**
**Phone: 888-476-2669**
**Fax: 800-432-9762**