State of Wisconsin
University Of Wisconsin System
UW-
UWS/OSLP-1Emp (03/02)

EMPLOYEE'S WORK
INJURY AND ILLNESS REPORT

PLEASE TYPE OR PRINT

INSTRUCTIONS:
1. **Complete within 24 hours of the injury.**
2. **Sign and date the completed report**
3. **Submit to your supervisor to complete the WKC-12 form.**
4. **Direct any questions to your agency Worker's Compensation Coordinator.**

FOR AGENCY USE ONLY
Claim Number
Claim Examiner / Representative

Employee Name (as it appears on payroll)	Time of Injury AM PM	Date of Injury
Work Telephone ( ) / Home Telephone ( )	Social Security Number *	
Was Medical Treatment Required? ☐ Yes ☐ No First aid only ☐ Yes ☐ No Time Lost From Work ☐ Yes ☐ No Last day worked (MM / DD/ YY)	Name and Address of Treating Practitioner/Facility	
Exact location of where accident took place (inside, outside, building name, room, vehicle, etc.)		
Witnesses (names, addresses, work telephone numbers)		
Describe in detail what you were doing when the injury /illness occurred. How exactly did it happen?		
Date the injury / illness reported to my supervisor (Month, Day, Year)		

Part of body injured (Check ***ALL*** that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)

	Abdomen		Back U M L		Finger R L 1 2 3 4 5		Head		Mouth		Shoulder R L				
	Ankle R L		Eye R L		Foot R L		Knee R L		Neck		Toe R L 1 2 3 4 5				
	Arm R L		Elbow R L		Hand R L		Leg R L		Nose		Wrist R L				
	Other (Please specify)						For Hand and Arm injuries circle your dominant arm : Right Left								

Have you ever been treated for a similar injury or condition? ☐ Yes ☐ No	If Yes Date(s) of Treatment	Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury:

Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the State of Wisconsin, University Of Wisconsin System, Office of Safety and Loss Prevention, Worker's Compensation Department, or its designated representatives, at P.O. Box 8010, Madison, WI 53708-8010

✍ **Employee Signature** _____ **Date** _____

FOR AGENCY USE ONLY	**PRIMARY ORGANIZATION CODE**	**FUND NUMBER**	**%**
	1 -**2 8 5** - **0** ___ - ___ ___ - ___ ___ ___ ___ ___ ___ ___		
	SECONDARY ORGANIZATION CODE	**FUND NUMBER**	**%**
	1 -**2 8 5** - **0** ___ - ___ ___ - ___ ___ ___ ___ ___ ___ ___		

LOSS DESCRIPTION CODES	**CAUSE / OCCURRENCE**	**OBJECT**	**RESULT**	**LOCATION**	**OCCUPATION**
	___ ___ ___ ___	___ ___ ___	___ ___ ___ ___	___ ___ ___	___ ___ ___ ___

OSHA CODES	Incident was OSHA "recordable"? ☐ Yes ☐ No	
Name of Authorized Representative		Date

***Your Social Security Number must be provided and will be used for positive identification in the processing of any claims.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)]. (**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
UW-Eau Claire	**6911350005**	☒ Yes ☐ No	**Higher Education**

Employer Mailing Address	City	State	Zip Code	Employer FEIN
105 Garfield Avenue	**Eau Claire**	**WI**	**54702-**	**39 - 6006492**

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
UW System OSLP (State of WI)	**39 - 6006492**

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. $	

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was the Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

State of Wisconsin
University of Wisconsin System
UW-System
UWS/OSLP-2 (2/98)

SUPERVISOR'S ACCIDENT ANALYSIS AND PREVENTION REPORT

SUPERVISOR'S REPORT

INSTRUCTIONS:

1. **Within 24 hours of notice of the accident**, **complete this report.**
2. **Send report to the Worker's Compensation Coordinator.**
3. **If you were not present at the time of injury, interview the employee.**

Employee Name	Social Security Number Job Classification
Department Name and Location Work Unit	
Date of Accident Time of Accident / /	Date injury reported / /

ACCIDENT DESCRIPTIONS: From your analysis, describe in detail the action, occurrence or event that resulted in the accident. Identify the exact location where the accident took place: ***Repetitive activities, lifting or material handling***, exposure to chemicals, push/pull or slip and fall, etc. If equipment related, was it defective? Could it be modified to prevent further injuries? Were safety procedures followed? Have employe's job duties changed recently? If so please explain.

Safety devices or other equipment in use at time of accident:

What action could be taken to prevent a similar accident?

Do you agree with the employee's account of the accident? ☐ Yes ☐ No If NO, Please explain.

Has the employee ever reported any previous physical condition(s) associated with work or non-work activities (second job, sports, etc. that could be related to or aggravated by this injury / illness? ☐ Yes ☐ No If YES, please explain

Supervisor's Name (Please Print)	Date
Title	Phone # ( )

If injury involved repetitive motion or material handling, Supervisor must complete next page

SUPERVISOR'S EVALUATION OF REPETITIVE MOTION AND/OR MATERIALS HANDLING ACTIVITIES

Repetitive Motion: What specific activities does the employee perform with his/her wrists, hands, arms, shoulders, and/or neck?

How many hours per day?_____ How many hours per week?_____

Material Handling Injury: Description of object/person being handled/lifted at time of injury.

Approximate size:_____ Approximate weight:_____

With what frequency, pace and duration is the object/person handled/lifted? (eg, 10 times/hour for 3 hours)

What material handling equipment and/or safety devices were available to the employee? Were they used properly?

Has the employee received training in proper body mechanics/lifting techniques? If YES, please indicate approximate date and type of training given.

WORKER'S COMPENSATION
FACT SHEET

The Worker's Compensation Act provides benefits when at the time of injury the employee is performing service growing out of and incidental to his or her employment. Injuries should be immediately reported to your supervisor who will provide an Employee Occupational Injury and Illness Report.

You have the choice of physician, chiropractor, psychologist or podiatrist licensed in the State of Wisconsin to provide reasonable and necessary treatment to cure and relieve the effects of injury. You have the choice of a second physician. Simultaneous treatment by two doctors is not accepted, nor is a third choice of physician unless referred by your primary doctor. Doctors within a clinic are not considered a change of doctors.

The Worker's Compensation Act provides payment for medical treatment to cure and relieve the effects of injury. Compensability is determined following evaluation of medical support that treatment relates to the work injury. Seeking treatment does not guarantee medical expense will be approved under Worker's Compensation.

When you seek medical treatment, advise the provider you have a worker's compensation claim. Medical bills should be submitted to your campus worker's compensation coordinator. Should you receive medical bills, including prescriptions, submit them to the worker's compensation coordinator on your campus.

The State of Wisconsin utilizes medical case management services to injured State employees. Medical care and services, such as inpatient hospitalizations, surgical procedures, MRI and CT scans, physical therapy and chiropractic treatment may be reviewed for appropriateness. If such treatment is recommended by your health care provider, promptly notify your worker's compensation coordinator prior to having such treatment.

Should an injury result in more than three days lost time from work, contact your worker's compensation coordinator. Medical documentation is required to substantiate disability payments under Worker's Compensation.

For further information regarding worker's compensation, please contact:

Laura Manydeeds, Worker’s Compensation Coordinator

UWEC – Human Resources

105 Garfield Ave.

Eau Claire, WI 54702

715-836-2514

This Fact Sheet briefly explains options available under the Wisconsin Worker's Compensation Act. This document does not constitute a legal document. The law and bargaining unit agreement would prevail in the event of a discrepancy.

WORKERS COMPENSATION
FACT SHEET
LOST TIME

When a work related injury or illness results in absence from work, a medical report is required giving the reason and dates of lost time. It is the responsibility of the employee to be sure medical reports are provided timely at the onset of disability as well as on a regular updated basis, including estimated return to work dates. Lack of complete medical documentation may result in a delay of payments.

Temporary disability benefits are approximately two-thirds of the employee's average weekly wage subject to a maximum amount specified by law. Temporary total disability is paid on a six-day per week basis. Payments are made to coordinate with regular scheduled payroll dates. Temporary disability is not paid for the date of injury or when three-day waiting period for disabilities lasting seven days or less. If the absence extends beyond eight days after the date of injury or last day worked, compensation is paid for the entire period including the three day waiting period.

Temporary disability is paid while **medical documentation** shows the employee is unable to work due to the work injury, until the employee is released by the physician and work is available within any restrictions, or until the employee reaches a maximal healing.

The University of Wisconsin System encourages early return to work. Contact your department to see if modified duty is available within your restrictions.

Leave Options

Temporary disability compensation can be supplemented with your **accumulated leave credits**. This allows employees to supplement their worker's compensation payment (approximately two-thirds of salary) with approximately one-third leave credits so they receive about their normal paycheck.

An employee cannot receive more than his/her regular base pay; therefore when credits are paid in addition to worker' compensation, an overpayment results. The payroll is reduced by this amount. The overpayment is divided by the hourly rate to determine the amount of leave credits to be credited to your account. Hours of leave credits restored are leave-without-pay.

An employee may elect to be on **leave-without-pay** during the period of absence and receive only temporary disability compensation. If this option is chosen, or the employee does not have enough leave credits to cover the absence, the employee would not be paid any accrued leave credits.

Leave credits are not **earned** for hours of leave-without-pay, including hours restored as a result of an overpayment.

Retirement credits are earned for any period of time in which temporary disability benefits under worker's compensation are paid provided the employee remains in active employment status. Upon return to employment, the employer may recover from the employee's payroll the amount of retirement contributions paid on their behalf during the disability.

Worker's compensation payments are **not taxable** for social security, federal tax or state tax.

Worker's compensation is integrated with Income Continuation Insurance. Benefits paid under worker's compensation will be deducted from any paid income continuation benefits.

If during the absence an employee is no longer on the payroll, you should **contact your Benefits Office to make arrangements for premium payment of benefits and/or insurance**, as well as appropriate leave of absence forms.

UNIVERSITY OF WISCONSIN SYSTEM
OFFICE OF SAFETY AND LOSS PREVENTION
WORKER'S COMPENSATION PROGRAM

Authorization to Use or Disclose Health Information to Worker's Compensation Self-Insurer

Injured Employee:

Worker's Compensation Claim Number:

Date of Birth:

Authorization Expiration Date: **UNTIL WORKER'S COMPENSATION CASE IS CLOSED.**

1. I authorize any health care providers/physicians/ psychologists/psychiatrists to provide record copies.

2. I authorize my entire record to be disclosed to University of Wisconsin System, or their representatives representing the State of Wisconsin

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to my Worker's Compensation self-insurer, the University of Wisconsin.

5. This information for which I'm authorizing disclosure will be used for management of my worker's compensation claim.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the University of Wisconsin System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my Worker's Compensation self-insurer, the University of Wisconsin System, when the law provides the System with the right to contest a claim.

7. I understand that my personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal privacy laws or regulations. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter of their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.

8. I understand that the health care provider may not condition my treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purposes of creating protected health information for disclosure to a third party.

9. This consent or photostatic copy of this authorization shall be as valid and effective as the original.

Signing this document will expedite the investigation of your claim and consideration of your receiving benefits. You may refuse to sign this document. However, this could delay the investigation of your claim, and may result in suspension of worker's compensation benefits.

_____ _____

Signature of injured employee or legal representative Authorization Date

_____

(If signed by legal representative, relationship to employee)

MEDICAL PROVIDER LIST

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

PLEASE USE THE BACK SIDE OF THIS FORM OR ANOTHER PIECE OF PAPER FOR ADDITIONAL MEDICAL PROVIDERS.

Return Forms To: **University of Wisconsin System Administration**
Office of Safety and Loss Prevention
Attn: Dawn Hass
780 Regent St.
Madison, WI 53715-2635