STARK COUNTY COMMISSIONERS
HUMAN RESOURCES DEPARTMENT
110 CENTRAL PLAZA SOUTH
SUITE 101
CANTON, OHIO 44702
Phone: 330.451.7999
Fax: 330.451.7906

Workers' Compensation
Supervisor's Responsibilities

1) **ASSIST** the injured worker in obtaining immediate medical assistance and an Injured Workers' Packet.

   - Should an injury occur due to the potential use of a controlled substance such as alcohol or drugs, specify drug and alcohol testing for injured employee at medical facility – please use reasonable judgement with regard to the nature of the accident/incident/injury when making this request.

   - If an injured worker is rushed to a medical facility and an "Injured Workers' Packet" is not presented to the injured worker before arrival at medical facility, Supervisor's please relay the following information to the medical staff if requested;

SEND CLAIM FORMS (FROI) & MEDICAL BILLS DIRECTLY TO:

SEDGWICK
PO Box 1040
Dublin, OH 43017
Phone: 888-247-7799
FAX: 888-711-9284
Employer Policy #: 37600001-0

   - Assist the treating physician/medical facility by relaying your Company's Workers' Compensation Representative's information, as necessary, if requested;

Stark County Commissioners
Workers' Compensation Coordinator:
Name: Brittany Musisca
Email: brmusisca@starkcountyohio.gov
Phone: 330.451.7999
Fax: 330.451.7906

2) **ENSURE** that the injured worker completes the following forms during the same shift/day as injury occurred with regard to extenuating circumstances of accident/injury;

- **Accident Report**, ("Employee's Report of Incident and/or Injury") and ("FROI-1", First Report of Injury - BWC)
- **Medical Release**, ("Stark County Commissioners Authorization to Release Medical Information") and in addition receives an injured workers' packet, provided by Stark County Commissioners HR dept.
- ***ALWAYS have the employee fill out the Accident & Medical forms listed above as soon as possible.***

3) **NOTIFY** Stark County Commissioners HR dept. (330-451-7513) within 24 hours of injury if medical attention was sought by the injured worker at a medical facility including chiropractic, Emergency, Urgent Care, (PCP) Primary Care Physician etc...

4) **RETAIN** all completed documents, if treatment was offered to the injured worker upon occurrence of accident/injury but the IW did not seek any medical attention per their judgement/request, notate this status on the injured workers' injury report and retain in their employee medical file within the employees home department personnel office. Workers' Compensation forms need not be processed if the injured worker did not receive any medical services however, it is important to keep track of the injury. There may be a safety concern in an area that could be addressed to lessen the frequency of reportable injuries.

5) **INVESTIGATE** the injury to ensure appropriate safety measures are in place. Complete form; Supervisor's Accident/Investigation Form and submit a copy to Brittany Musisca. Request witness statements (same shift/day as injury) as applicable, and submit a copy to Brittany Musisca. Have the injured workers job description available, it may be requested by BWC & Sedgwick to assist in processing the claim.

6) **MAINTAIN** communication with the injured worker and Stark County Commissioners HR dept. and Sedgwick.

7) **REQUEST** "Return to Work" paperwork **or** "Modified Duty Status" paperwork from the Injured Worker within 24 hours of the IW receiving medical care – when an IW will have modifications/restrictions ("light duty"), to their job duties or be unable to work.

   a) Acceptable paperwork will be signed & dated by the physician- on the medical facility's letterhead indicating the type of modified duty and/or restrictions, if any, and the date range such restrictions are to commence and end.

      i) For example; ***John Smith is on restricted light duty and will be unable to lift more than 10 lbs from August 4, 2015 – September 25, 2015. It is expected that the patient will return to full*-duty on Sept. 26, 2015.**

b) If the injured worker is unable to return to work, the physician is to notate the date the IW will not be able to work and the expected date that they will return to work.

   i) **For example**; ***Due to injury, Cary Jones will be unable to work from; Dec. 1, 2015 – Dec. 20, 2015. The patient is expected to return to work on December 21, 2015. The patient has a follow-up visit on Dec. 18th.***

c) Scheduling can be a concern when an employee is off of work due to a workers' compensation claim. If the IW is unable to come in to work to provide "return to work" (RTW) paperwork, the Supervisor may call or email the IW to request and obtain this information.

   i) The RTW documents may be emailed, faxed or mailed to the IW's supervisor/department.

   ii) The IW will need to RTW on the date listed by the physician, unless an updated physician's note supersedes the former note (during a follow-up visit) and the IW provided the paperwork to the Supervisor upon receiving the updated fit-for-duty status paperwork.

d) In addition, the physician is to notate the expected full-duty status date for the IW on the return to work paperwork – if the IW was initially placed on light duty or off of work.

   i) **For example**; ***John Smith will return to "full-duty" on January 15, 2016.***

   ii) **For example**; ***Upon returning to work, Cary Jones will be on restricted duty – not able to walk up/down stairs and unable to squat, bend or kneel – from Dec. 21, 2015 – Jan. 21, 2016. It is expected that she will return to full-duty on Jan. 22, 2016.***

8) **INFORM** the injured worker of available resources should they have questions;

   a) BWC website : https://www.bwc.ohio.gov/
   b) Stark County Human Resources website : http://www.starkcountyohio.gov/human-resources

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Supervisor's Accident Investigation Form

Please complete this form within 48 hours of the accident/injury.

Name of Injured Employee: _____ ***Date of Injury:*** _____ ***Date Form Completed:*** _____

Name of Supervisor to the Injured Employee: _____ **Dept:** _____ **Phone:** _____

When was the Supervisor notified? _____ **Who relayed the injury information to you?** _____
Date & Time *Employee Name*

Date and Time the Injured Employee filled out the *Report of Incident/Injury Form*: _____

Describe the Injured Employee's job duties when the injury occurred: _____
_____

Are the job duties described above, the Injured Employee's regular job duties?: ☐ **Yes** ☐ **No**
If no, why the change in job duty?: _____

Injury Information

Describe how the accident/injury happened: _____
_____
_____
_____
_____
_____

Location of accident/injury: _____ **Time injury occurred?:** _____
Time & am/pm

Describe the type of injury being claimed?: _____
(Hip, Knee, ankle, shoulder, area of back etc...)

Was the Injured Employee performing work or job duties when the injury occurred?: ☐ **Yes** ☐ **No**

Was the Injured Employee injured either before starting work or after leaving work?: ☐ **Yes** ☐ **No**

Are you aware of any other similar injuries that the Injured Worker has claimed, discussed or mentioned?: ☐ **Yes** ☐ **No**

If yes, what type of injury (similar in nature)?: _____ **When did it happen?** _____
Type of former similar injury *Approximate date of former injury*

Did anyone physically witness the accident/injury?: ☐ **Yes** ☐ **No**

If so, did the witness(s) agree to fill out a *Witness Report Form*?: ☐ Yes ☐ No **If so, when?:** _____
Date & Time witness form completed

Name of the Witness(s): _____ _____ _____

Safety Information

Was safety equipment or devices being utilized during time of accident/injury?: ☐ Yes ☐ No ☐ N/A

If no, was the safety equipment or devices available to the Injured Employee?: ☐ Yes ☐ No

Is the Injured Employee trained on the safety equipment and devices used while performing their job?: ☐ Yes ☐ No ☐ N/A

Did the Injured Employee neglect to use the required or offered safety equipment and devices?: ☐ Yes ☐ No

In your opinion as a Supervisor, was this work injury preventable?: ☐ Yes ☐ No If yes, how?: _____

_____

Did the Police respond to the scene of the that accident/injury?: ☐ Yes ☐ No
If yes, what was the Report Number, and who was the responding Officer?:_____

_____

Safety suggestions: _____
_____

Medical Information

Did the Injured Employee utilize offered medical services at the time of accident/injury?: ☐ Yes ☐ No
If yes, where did the Injured Employee go for medical service?: _____
If no, why did the Injured Employee refuse medical service?: _____
_____

Did the Injured Employee come back to work the same shift/day following the accident/injury? ☐ Yes ☐ No

Did the Injured Employee take time off from work following accident/injury?: ☐ Yes ☐ No

Did the Injured Employee provide management with a Physicians note stating time/dates off of work?: ☐ Yes ☐ No ☐ N/A
If yes, state date range for time off: _____ Expected return to work date: _____

Has the Injured Employee requested work accomodation due to accident/injury with a physicians note?: ☐ Yes ☐ No

Is the Employer able to accommodate the Injured Employees restrictions/work modifications?: ☐ Yes ☐ No ☐ N/A

What is the work restriction(s), if any: _____

Date: _____

Supervisor: (print) _____

Supervisor: (sign) _____

Please forward to the Stark County Workers' Compensation Generalist, if the injured worker sought immediate medical attention following an at work accident/injury, along with the *Report of Incident/Injury Form*. If medical attention was offered to the Injured Employee but not sought, please retain all documents in the employees medical file within the home department.

Contact: HR Generalist, Brittany Musisca Phone: 330.451.7999 * Fax: 330.451.7906 *
Email: brmusisca@starkcountyohio.gov

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Witness Statement Form – Injury at Work

Name of Injured Employee: (print) _____ **Shift:** _____

Job Title: _____ **Date of Injury:** _____ **Day of Week:** _____ **Dept.:** _____

Your name has been given as a witness to an incident alleged by the above individual.
Through your cooperation, information can be obtained to complete the investigation of this incident.
Therefore, it would be appreciated if you would answer each of the following questions and
promptly return your completed statement the same shift and day that the injury occurred.

Witness Name: (print) _____ **Job Title:** _____ **Dept.:** _____

Witness Address: _____ **City/State/Zip:** _____ **Phone Number:** ( ) _____

Did you physically witness an accident involving the above employee? □ **Yes** □ **No**

If yes, date of accident: _____ **Time:** _____ **If not, how did you learn about the accident?** _____

_____

STATEMENT

Describe in detail what you physically witnessed and/or heard regarding the employee alleging this accident: (Please print)

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information I have provided in this report is true and correct to the best of my knowledge. This report contains everything I can recall and I gave this statement within the same shift and day of witnessing said accident.

Witness Name: (print) _____ Signature: _____ Date: _____

Supervisor's Name: (print) _____ Supervisor Signature: _____ Date: _____