

Winona State University

Workers' Compensation Packet

Supervisor Responsibilities

1. Complete “First Report of Injury” form and “Agency Claims Investigation” form, and immediately send to Human Resources.
2. Have employee sign “Workers’ Compensation Leave Supplement” form and “Workers’ Compensation Program Department of Employee Relations Information and Privacy Statement” form. Immediately send both forms to Human Resources.
3. If employee requires medical care, send them to the Winona Clinic in Winona or Olmstead Medical Center in Rochester.
4. Employee should take the “Report of Work Ability” form and “CorVel Corporation Minnesota Certified Workers’ Compensation Manager Care Plan” form to the doctor.
5. “Report of Work Ability” form and/or doctor’s statement must be returned to Human Resources.

Minnesota Department of Employee Relations
 Workers' Compensation Division
 P.O. Box 64081
 St. Paul, MN 55164-0081
 (651) 259-3800

First Report of Injury

Enter dates in MM/DD/YY format.
**USING THIS FORM DOES NOT
 RELEASE YOUR RESPONSIBILITY IN
 ENTERING THE FIRST REPORT OF
 INJURY INTO SEMA4**



Do Not Use This Space

**AGENCY FRI WORKSHEET
 NOT IN GENCOMP**

1. EMPLOYEE SOCIAL SECURITY #		2. OSHA Case#			
3. DATE OF CLAIMED INJURY		4. Time of injury <input type="checkbox"/> AM <input type="checkbox"/> PM		5. Time employee began work on date of injury <input type="checkbox"/> AM <input type="checkbox"/> PM	
6. EMPLOYEE Name (last, first, middle)				7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	
				8 Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Unmarried	
9. Home address			10. Home Phone #		11. Date of Birth
City		State	Zip Code	12. Occupation	
				13. Dept/Location Code	
				14. Date Hired	
15. Average weekly wage		16. Rate per hour		17. Hours per day	18. Days per week
					19 Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Seasonal
					<input type="checkbox"/> Part-time <input type="checkbox"/> Volunteer
20. Weekly value of:		Meals	Lodging	2 nd Income	21. Apprentice <input type="checkbox"/> Yes <input type="checkbox"/> No
22. Tell us how the injury or illness occurred and what the employee was doing before the incident. (give details). Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under the drive shaft." "Worker developed soreness in left wrist over time from daily computer entry.					
23. What was the injury or illness (include the part(s) of body)? Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.			24. What tools, equipment, machines, objects, or substances were involved? Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.		
25. Did injury occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, indicate name and address of place of occurrence.		26. Date of first day of any lost time		27. Employer paid for lost time on day of injury (DOI) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No lost time on DOI	
		28. Date employer notified of injury		29. Date employer notified of lost time	
		30. Return to work date		31. Date of death	
32. TREATING PHYSICIAN (name, address, and phone)			33. HOSPITAL/CLINIC (name and address) (if any)		34. Emergency Room Visit <input type="checkbox"/> Yes <input type="checkbox"/> No
					35. Overnight in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No
36. EMPLOYER Legal name			37. EMPLOYER DBA name (if different)		
38. Mailing address			39. Employer FEIN		40. Unemployment ID#
City			State	Zip Code	41. Employer's contact name and phone #
42. Physical address (if different)			43. Witness (name and phone)		
City			State	Zip Code	44. NAICS code
					45. Date form completed
46. INSURER name State of MN – Dept of Employee Relations			51. CLAIMS ADJUSTER (CA) name (check one) <input type="checkbox"/> Insurer <input type="checkbox"/> TPA		
47. Insured legal name State of Minnesota			52. CA address P.O. Box 64081		
48. Policy # or self-insured certificate #			City St. Paul	State MN	Zip Code 55164-0081
49. Insurer FEIN 41-6007162		50. Date insurer received notice		53. CA Phone #	54. Claim #

MN FR01 (02/06) Copies to: Insurer (DOER), Employer (Agency) and Employee.

IMPORTANT NOTICE

Whenever you become aware of any work-related injury or illness that requires medical care or lost time from work, you must report the injury or illness to DOER as soon as possible. The filing of this report is not an admission of liability. If your agency has access to SEMA4, this report must be entered into SEMA4. (See the Workers' Compensation System User Guide Appendix A for Instructions on how to enter an FRI into SEMA4). If your agency does not have SEMA4, you must send your completed forms to DOER. The prompt filing of this report with DOER and the Department of Labor and Industry is required by law. The State of Minnesota is self-insured so there are 14 days to have the claim filed with the Department of Labor and Industry before becoming subject to penalties. You should file this report immediately with DOER using SEMA4 or if needed send the forms to DOER. This will allow DOER as much time as possible to investigate the claim based on the information you completed when filing the claim. Even if the claim is questionable, it is important that you report it promptly. If you question the claim, enter the information in the appropriate screen when filling in the claim information. Each case should also be recorded on your OSHA 300 log, if necessary. This form contains all items required by OSHA form 301.

GENERAL INSTRUCTION TO THE EMPLOYER

Death or serious injury arising from employment must be reported to the Department of Employee Relations within 24 hours of the occurrence. You may initially report by telephone (651) 297-1184, or facsimile (651) 297-5471, or personal notice within 24 hours, but the filing of this report in SEMA4 must follow the notice with DOER within three calendar days of the occurrence. If a reported injury subsequently results in death, a report of death must be made to DOER within 24 hours of when you are notified of the death.

If the employee cannot work for a period of more than three days, the workers' compensation claim must be entered into SEMA4 and sent to DOER electronically within three calendar days. DOER will forward any necessary forms to the Department of Labor and Industry.

Please type or print legibly. **The employee's immediate supervisor should complete this form.** It is absolutely essential that you fill in all the information you can. Each piece of information is needed to determine liability and entitlement to benefits. Failure to complete the form may result in delayed processing and possible penalties. Provide copies to DOER and your injured worker. If the claim results in the employee's inability to work for a period of more than three days, send a copy of this report to the employee's local union office. Fill in all the information you can, except items 46-54.

Form Instructions Employee Information

Item 1: Self-explanatory. **Required.**

Item 2: OSHA Case #. Fill in the case number from the OSHA 300 log. If sent via SEMA4 by your agency, the OSHA case number will be SEMA4's incident #.

Items 3 - 7: Self-explanatory. **Required information** on injured employee and the date of claimed injury. If the actual date is unknown due to continuous nature of injury, use date employee became aware there might have been a work-related injury.

Item 8: Check the appropriate box for Marital Status.

Item 9: Self-explanatory. **Required information** on injured employee.

Item 10: **Required.** Enter the employee's home phone number – need area code/telephone number.

Item 11: **Required.** Enter the date of birth of the injured employee.

Item 12: Enter the employee's classification code (6 digit number) and the employee's classification title. Your agency's personnel office has this information.

Item 13: **Required.** Enter the 6 digit code identifying the location where the injury occurred. Your agency's personnel office has this information.

Item 14: **Required.** Enter the date the employee was hired by the State of Minnesota (not agency).

Wage Information

Note: Wage information is required. Employee cannot be paid without completed information.

Item 15: To compute the average wage/week, multiply the number of work hours per day by the employee's hourly rate. Then multiply the result by the number of days per week. If the employee does not work the same number of hours each week or received differential or overtime pay in at least half of the 26-week time period preceding the injury, a 26-week wage statement must be attached.

Item 16: Enter the employee's current hourly rate.

Item 17: Enter the number of hours worked per day.

Item 18: Enter the number of days worked per week.

Item 19: Check the appropriate employment status.

Item 20: Record employee's additional income if appropriate such as second employment wages.

Item 21: Check "Yes" if the employee was in an apprenticeship program at the time of the injury.

Occurrence

Item 22: **Required.** Be as specific as possible in describing the events causing the injury. See examples on form, box 22.

Item 23: **Required.** Describe the body part (i.e., right hand, left leg, neck, shoulder, etc.) affected or injured and nature of the injury (i.e., cut, sprain, burn, etc.).

Item 24: **Required.** Name of the object (i.e., person, vehicle, machine, substance, etc.) that was involved in the injury/illness.

Item 25: Place where the accident occurred. Check appropriate box to answer whether or not the claimed injury occurred on or off the employer's premises.

Item 26: **Required if lost time.** Fill in the first day the employee lost time from work, even if you paid the employee for the full day.

Item 27: Check the appropriate box to indicate whether you paid for that lost time.

Item 28: **Required.** Be sure to fill in the date you **first** became aware of the injury or illness. This is used to determine whether the form is filed on time. You have three (3) calendar days from the date you became aware of the injury to report to and be received by the Department of Employee Relations, Workers' Compensation Program.

Item 29: **Required if lost time.** Record the date you were notified that the employee lost time from work. This item will be completed by the Department of Employee Relations upon notification by the agency that an employee is losing time after the First Report of Injury has previously been submitted by the agency.

Item 30: If the employee has not returned to work by the time you are filing this form, leave the box blank and call the Workers' Compensation Program when the employee returns to work. If the employee has returned to work, indicate the date on the form. Be sure to notify the Workers' Compensation Program immediately if the injured employee starts missing time due to this injury.

Item 31: A death must be reported to the Department of Employee Relations within 24 hours of an employee's death.

Item 32: Physician's name that treated the employee for his/her injury or illness.

Item 33: Name of the hospital or clinic who provided medical treatment to the employee.

Item 34: **Required.** Check the appropriate box whether there was an Emergency Room visit.

Item 35: **Required.** Check the appropriate box whether there was an Overnight in patient stay.

Employer

Item 36: **Required.** Enter the agency name.

Item 37: Leave blank.

Item 38: Enter the address of the employer.

Item 39, 40 & 44: Do not fill in. The Department of Employee Relations will add this information.

Item 41: **Required.** Enter the name of your agency's representative, title and telephone number. This should be your agency's director, personnel director or workers' compensation coordinator.

Item 42: Leave blank.

Item 43: Name (first and last) of any witness (es) to the accident and their telephone number.

Item 45: **Required.** Date form is completed by the agency. If sent via SEMA4 by your agency, this will be SEMA4's send date.

Insurance

Items 46 – 54: Do not fill in. The Department of Employee Relations will add this information.

SEND REPORT IMMEDIATELY TO YOUR AGENCY REPRESENTATIVE – DO NOT WAIT FOR DOCTOR'S REPORT

DOER will send a copy of the final FRI to the agency and the employee.

This material can be made available in different formats, such as large print, Braille or on a tape. To request an alternate format, call (651) 296-6521 or Fax (651) 297-5471 or TDD (651) 282-2699.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

Agency Claims Investigation

(SEMA4 panels are in italics)

Workers' Compensation Division
P.O. 64081
St. Paul, MN 55164-0081
(651) 259-3800
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>(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>
	<u>Primary Hazard Condit Code:</u>

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>	
<u>Primary Unsafe Act Code:</u>	

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>	
Name _____ Phone _____	
Title _____ Date of Investigation _____	
14. Agency management review	
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 Employee Relations 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 Department of Employee Relations 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 Employee Relations (DOER) 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 DOER 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 Employee Relations 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 DOER;
 - 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 the non-investigative claim information maintained by the Department of Employee Relations, 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

WORKERS' COMPENSATION LEAVE SUPPLEMENT

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.

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 not 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

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

Under Minnesota Rule 5218.0250, the Minnesota Department of Employee Relations provides this notice to inform you that:

Effective July 1, 2005, your employer (the State of Minnesota) will be enrolled with **CorVel**, a certified workers' compensation managed care plan that provides state employees and student workers 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. As a state employee or student worker, you must receive all necessary medical treatment 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.

On July 1, you can 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.doer.state.mn.us> (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) 296-6521. You may also contact your agency's Workers' Compensation Coordinator (Ilene Trittin-Anderson in Human Resources, 218/477-2067) if you need assistance. **MSUM has designated Innovis for initial intake and assessment of work related injuries.**

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.

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: MN Department of Employee Relations

Administrator Phone: 651-259-3800

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.

*REPORT OF WORK ABILITY

CorVel Corporation, 3001 NE Broadway St #610, Minneapolis MN 55413
Telephone (866)399-8541 or (612)436-2542 ~ Fax (612)436-2499

1. PATIENT INFORMATION		
Last Name	First	Middle Initial
Social Security Number	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)	
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"/> 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;"> <thead> <tr> <th></th> <th>none</th> <th>1-2</th> <th>2-4</th> <th>4-6</th> <th>6-8</th> <th>none</th> <th>1-2</th> <th>2-4</th> <th>4-6</th> <th>6-8</th> </tr> </thead> <tbody> <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 style="text-align: right;">Sit</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> </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 style="text-align: right;">Drive</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> </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 style="text-align: right;">Push / Pull</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> </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><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td> </tr> </tbody> </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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>	
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Other Restrictions: _____																																																												
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