COUNTY MUTUAL

CARE LINE

Powered by Guardian MCS

CALL THE CARE LINE:

1-833-564-0894

MANDATORY FOR USE ON ALL WORK RELATED INJURIES

THE CARE LINE MUST BE UTILIZED ON ALL WORK-RELATED INJURIES.

You will need to report the incident to your supervisor or the individual designated to receive worker's compensation claims to note the event.

All serious injuries should be treated immediately and reported as soon as possible. All other injuries should utilize the Care Line® Nurse to assess the injury and provide helpful instructions.

IN CASE OF EMERGENCY - DIAL 911

WORKER'S COMPENSATION
CLAIM KIT

INSTRUCTIONS

SOFTWARE REQUIREMENTS

To view, complete, and print this application, you will need Adobe Reader or Adobe Acrobat software. This product is available for free download by visiting http://www.adobe.com/products/reader. The Adobe Acrobat product is a paid product. The program and associated licenses can be purchased at http://www.adobe.com/products/acrobat.

PDF CONTENTS

- PDF Instructions (1 page)
- First Notification of Injury Form (2 pages)
- Physician's Return to Work Recommendations Record (1 page)
- Release of Medical Records Authorization (1 page)

COMPLETING THE FORMS ELECTRONICALLY

1. Open the PDF file
2. Click 'Save As' to save a new specific copy of the file. Not doing so will cause your master copy to overwrite any previous versions, or cause your file to be deposited into your Temporary folder.**
3. To enter text: Click your cursor over the designated field, your text cursor will display. Begin typing information into the field. Some fields will require information to be explained in detail- these fields are formatted to fit text on multiple lines. Text in these fields will get progressively smaller and automatically start a new line.
4. Check Boxes: Some questions will require a 'YES' or 'NO' answer or ask you to check a specific reply. Click the box containing your desired response, and a blue check mark will appear.
5. Once completed, save your file and print the form. Please sign.

***The ability to save individual copies of forms is only available with Adobe Acrobat. Adobe Reader users are required to print their records and scan them for digital storage.*

IMPORTANT

- **THE 'FIRST NOTIFICATION OF INJURY' DOCUMENT IS TO BE FILLED OUT BY BOTH THE INJURED EMPLOYEE'S SUPERVISOR (1ST PAGE) AND THE INJURED EMPLOYEE (2ND PAGE).**
- **THE 'PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD' DOCUMENT IS TO BE FILLED OUT BY THE INJURED EMPLOYEE'S ATTENDING PHYSICIAN, AND NOT A NURSE OR PHYSICIAN'S ASSISTANT.**

WORKER'S COMPENSATION

FIRST NOTIFICATION OF INJURY FORM

TO BE COMPLETED BY THE SUPERVISOR

SUPERVISOR'S REPORT

INJURED PERSON: _____ DATE: _____ CHECK ONE ☐ EMPLOYEE ☐ VISITOR ☐ VOLUNTEER

NAME AND POSITION OF PERSON PREPARING REPORT: _____

DEPARTMENT: _____ SUPERVISOR'S PHONE NUMBER: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ A.M. ☐ P.M. LEFT WORK? (CLICK) YES NO

ADDRESS OF ACCIDENT: _____

WHAT WAS THE EMPLOYEE DOING WHEN INJURED? BE SPECIFIC. PLEASE NAME ANY EQUIPMENT USED.

HOW DID THE ACCIDENT OCCUR?

HOW LONG HAS THE EMPLOYEE BEEN ON THE JOB? _____ DAYS _____ MONTHS _____ YEARS

WHAT SAFETY EQUIPMENT IS REQUIRED ON THE JOB FOR THE WORK BEING PERFORMED?

WAS THE EMPLOYEE USING ALL REQUIRED SAFETY EQUIPMENT? (CLICK) YES NO

IF NO, WHICH SPECIFIC PERSON PROTECTIVE EQUIPMENT WAS NOT USED & WHY?

DOES AN UNSAFE CONDITION EXIST THAT CONTRIBUTED TO THE CAUSE? (CLICK) YES NO

IF YES, WHAT IS THE CONDITION?

HOW COULD THIS ACCIDENT BEEN PREVENTED?

CORRECTIVE ACTION TAKEN BY SUPERVISOR? (CLICK)	YES	NO	DATE:
REINSTRUCTION OF PERSON(S) INVOLVED?	YES	NO	
EQUIPMENT REPAIR/REPLACEMENT?	YES	NO	
IMPROVED PERSONAL PROTECTION EQUIPMENT?	YES	NO	
REDUCED CONGESTION?	YES	NO	
IMPROVED DESIGN/CONSTRUCTION?	YES	NO	
DISCIPLINE OFPERSON(S) INVOLVED?	YES	NO	

OTHER: _____

IN DETAIL, PLEASE EXPLAIN ACTION TAKEN TO PREVENT RECURRENCE:

TO BE COMPLETED BY THE INJURED EMPLOYEE

EMPLOYEE INFORMATION

NAME: | SSN: | GENDER ☐ M ☐ F | HOME PHONE :

ADDRESS: | CITY: | STATE: | ZIP:

BIRTHDATE:

EMPLOYMENT HISTORY

OCCUPATION: | DEPARTMENT: | DATE HIRED:

ACCIDENT INFORMATION

DATE OF INJURY: | TIME OF INJURY: | DATE REPORTED:

NAME OF INDIVIDUAL THE INJURY WAS REPORTED TO:

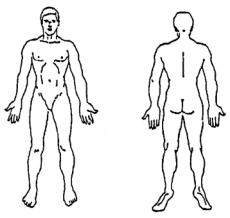
IN YOUR OWN WORDS, EXPLAIN IN DETAIL WHAT YOU WERE DOING IMMEDIATELY BEFORE THE ACCIDENT AND HOW THE ACCIDENT OCCURRED:

WITNESS?: | DID/WILL YOU SEEK MEDICAL TREATMENT? (CLICK) **YES** **NO**

IF YES, PLEASE PROVIDE PHYSICIAN:

CLINIC:
PHYSICIAN:
ADDRESS:
PHONE:

INDICATE ON THE DIAGRAM THE LOCATION OF INJURY



DESCRIBE SYMPTOMS:

I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

DATE: | SIGNATURE:

EMPLOYER SECTION:

PLEASE CHECK ONE:

EMPLOYEE HAS NOT MISSED TIME FROM WORK ☐
EMPLOYEE IS OFF WORK ☐

IF EMPLOYEE IS OFF WORK, PLEASE INDICATE REASON

AUTHORIZED OFF WORK ☐
WORK RESTRICTIONS ☐

PLEASE SUBMIT REPORT TO:

COMPANY	Aegis LLC
NAME	Abigail Schmitz
PHONE	1-262-289-1171
FAX	262-252-6577

PLEASE BE SURE TO ATTACH A COPY OF THE PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE

FAX REPORT TO AEGIS CORPORATION AT 262-252-6579 WITHIN 24 HOURS

SUPERVISOR OR HR REPRESENTATIVE: | PHONE:

WORKER'S COMPENSATION

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

EMPLOYER NAME: _____

CLAIM NUMBER: _____

PATIENT NAME: _____ DATE OF INJURY: _____

TO BE COMPLETED BY **ATTENDING PHYSICIAN** - PLEASE CHECK

DIAGNOSIS/CONDITION (BRIEF EXPLANATION) _____

I SAW AND TREATED THIS PATIENT ON _____ (DATE) AND BASED ON THE ABOVE DESCRIPTION OF THE PATIENT'S CURRENT MEDICAL PROBLEM:

1. ☐ RECOMMEND HIS/HER RETURN TO WORK WITH NO LIMITATIONS ON: _____ (DATE).

2. ☐ HE/SHE MAY RETURN TO WORK ON: _____ (DATE) CAPABLE OF PERFORMING THE DEGREE OF WORK CHECKED BELOW WITH THE FOLLOWING LIMITATIONS:

☐ **SEDENTARY WORK**. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involved sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **LIGHT WORK**. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree of when it involved sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **LIGHT MEDIUM WORK**. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **MEDIUM WORK**. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **MEDIUM HEAVY WORK**. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **HEAVY WORK**. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. **In an 8-hour work day, the patient may:**

a. Stand/Walk
☐ NONE ☐ 1-4 Hours ☐ 4-6 Hours ☐ 6-8 Hours

b. Sit
☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

c. Drive
☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours

2. **Patient may use hand(s) for repetitive:**
☐ Single Grasping
☐ Pushing or Pulling
☐ Fine Manipulation

3. **Patient may use foot/feet for repetitive movement as in operating foot controls:**
☐ YES ☐ NO

4. **Patient is able to:**

	FREQUENTLY	OCCASIONALLY	NOT AT ALL
Bend	☐	☐	☐
Squat	☐	☐	☐
Climb	☐	☐	☐
Twist	☐	☐	☐
Reach	☐	☐	☐

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS: _____

THESE RESTRICTIONS ARE IN EFFECT UNTIL: _____ (DATE) OR UNTIL THE PATIENT IS RE-EVALUATED ON: _____ (DATE).

3. ☐ HE/SHE IS TOTALLY INCAPACITATED AT THIS TIME. PATIENT WILL BE RE-EVALUATED ON: _____ (DATE).

NAME OF PROVIDER: _____ DATE: _____

PHYSICIAN: _____

PHYSICIAN'S SIGNATURE: _____

Aegis CORPORATION

AEGIS LLC - A Charles Taylor Company
18550 WEST CAPITOL DRIVE, BROOKFIELD, WI 53045
TOLL FREE: 1-800-236-6885 LOCAL: 262-781-7020 FAX: 262-781-7743 EMAIL: BReid@aegis-wi.com

WORKER'S COMPENSATION

RELEASE OF MEDICAL RECORDS AUTHORIZATION

By law, all health care providers must provide any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury:

NAME OF PROVIDER:			
PROVIDER ADDRESS:			
PHYSICIAN:		**EMPLOYER NAME:**	
PATIENT NAME:		**PATIENT D.O.B.:**	
PATIENT SSN:		**WC CLAIM NO.:**	

The patient named above hereby authorized the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment, and evaluation to:

NAME & ADDRESS OF PARTY AUTHORIZED TO RECEIVE PROTECTED INFORMATION:

Aegis LLC - A Charles Taylor Company
18550 West Capitol Drive
Brookfield, WI 53045

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes all records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

PHYSICAL ONLY:
Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or ay other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 51.30, 146.025, 146.81, and 146.82, 42 C.F.R., Chap. 1, subpart C., § 2.31 and 45 C.F.R. § 164.508.

In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment,enrollment or eligibility for benefits (if applicable) 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 purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization. Any by notifying the disclosing medical records/health information department in writing.
- I may obtain a copy of the disclosed medical records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. 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 or their attorneys; the Labor and Industry Review Commission; any court on any action of 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.
- I am entitled to a copy of this consent form after I sign it.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that is must be used within a certain number of days after the date of signing, or that is must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy shall be valid as the original.

PATIENT SIGNATURE
(OR PERSON AUTHORIZED TO SIGN FOR PATIENT):

DATE: