CITY OF MACEDONIA
HUMAN RESOURCES DEPARTMENT
9691 VALLEYVIEW ROAD
MACEDONIA, OHIO 44056
Phone: 330.468-8353
Fax: 330.468-8354

Workers’ Compensation
Supervisor’s Responsibilities

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

   - According to the City's "Drug Free Workplace" Program, drug and alcohol testing for injured employee at medical facility is mandatory.

   - 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 MEDICAL CLAIMS & BILLS DIRECTLY TO:
1-888 Ohio Comp
1-888 Ohio Comp
2900 Carnegie Ave.
Cleveland, Ohio 44115
Phone: 888-644-6266
FAX: 888-644-6266

Employer Policy #: 37705802

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

City of Macedonia
Workers’ Compensation Administration:
Name: Annette Smith
Email: asmith@macedonia.oh.us
Phone: 330.468-8353
Fax: 330.468-8354

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;

University Hospitals

Occupational Health Locations

Parma
6115 Powers Blvd. Suite 200
Parma, OH 44129
440-743-7373
Walk-in Monday-Friday 7:30a-4:00p

Ashland
2212 Mifflin Ave. Suite 215 Ashland,
OH 44805
419-281-4440
Walk-in Monday-Friday 8:00a-4:30p

Beachwood
3619 Park East Drive Suite 205
Beachwood, OH 44122
216-464-6211
Walk-in Monday-Friday 7:30a-4:00p

UH Ahuja Medical Center ER
3999 Richmond Road,
Beachwood Ohio 44122
(216) 593-5500
Emergency and after hour care

Portage
3957 Loomis Parkway
Ravenna, OH 44266
330-297-2385
Walk-in Monday-Friday 7:30a-4:00p

- **Accident Report**, ("Employee's Report of Incident and/or Injury") and ("FROI-1", First Report of Injury - BWC)

- **Medical Release**, ("City of Macedonia's Authorization to Release Medical Information") and in addition receives an injured workers' packet, provided by City of Macedonia's HR dept. (Packets also provided to each Department Head)

- ***ALWAYS have the employee fill out the Accident & Medical forms listed above as soon as possible.***

3) **NOTIFY** the City of Macedonia's HR dept. (330-468-8353) 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 judgment/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 Annette Smith. Request witness statements (same shift/ day as injury) as applicable, and submit a copy to Annette Smith. Have the injured workers job description available, it may be requested by BWC & 1-888 OhioComp to assist in processing the claim.

6) **MAINTAIN** communication with the injured worker, the City of Macedonia HR dept. and 1888 OhioComp.

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

   ii) <u>For example</u>; ***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) City of Macedonia website : http://www.cityofmacedonia.oh.us

University Hospitals
Occupational Health Services

Employer's Authorization for Examination or Treatment

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name	Date of Birth	SSN	Job Title

Patient Phone Number	Full-Time/Part-Time	Date of Injury/Incident

City of Macedonia	9691 Valley View Road, Macedonia, Ohio 44056	
Full Name of Company	Address	Company Box Code (For Drug Results Access)

Physical Examinations

- ☐ Post Offer/Basic
- ☐ OP&F Pension Fund
- ☐ Annual
  - ☐ NFPA ☐ HAZWOPR ☐ Other:
- ☐ HAZMAT
  - ☐ Chagrin/S.E. ☐ Other:
- ☐ DOT
  - ☐ Pre-Employ ☐ ReCertification
- ☐ Bus (T8)
- ☐ Respiratory
- ☐ Asbestos
- ☐ Return To Work
- ☐ Fit For Duty/Assessment
- ☐ Other:

Substance Abuse Testing

- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Work Related Injury/Illness/ Post Accident - TREATMENT SOUGHT
- ☐ Follow-Up/Return To Work Other:
- ☐ Urine Drug Screens
- ☐
  - ☐ Dot ☐ 5 Panel ☐ 10 Panel-NO TREATMENT
  - ☐ 12 Panel ☐ 5 Panel Rapid
  - ☐ 11 Panel Rapid ☐ Other
  - ☐ W/Nicotine
- ☐ Urine Collection Only
  Send to:
- ☐ Breath Alcohol Test
  - ☐ Regulated ☐ Non-Regulated
- ☐ Hair Collection

Other Services

- ☐ BWC Injury/Followup Care
- ☐ Respirator Clearance
- ☐ Respirator Fit Test
  - ☐ Qualitative ☐ Quantitative
- ☐ Hepatitis A Vaccine
- ☐ Hepatitis B Vaccine (Series of 3)
- ☐ Hepatitis B Antibody
- ☐ TB Test
  - ☐ Skin ☐ T-Spot
- ☐ Tdap
- ☐ MMR
- ☐ PFT
- ☐ Audiogram
- ☐ Other:

Billing

☐ BAT/UDS services as part of injury, illness or follow-up care:
Bill the **CORPORATE HEALTH PLAN**

☐ Injury Care: Bill the **WORKER'S COMPENSATION CARRIER**

Carrier: ____________________

Policy Number: ____________________

Phone: ____________________

Address: ____________________

☐ Pre-Employment/Annual Occupational Health Services, Random and Reasonable Suspicion UDS: Bill the **CITY OF MACEDONIA**

☐ Employee to **SELF-PAY** at the time of service

IS TRANSITIONAL WORK/LIGHT DUTY OFFERED TO THE INJURED WORKER? ☐ Yes ☐ No ONLY IF TREATMENT IS SOUGHT

Authorized By	Title

Phone	Date

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Incident Investigation Report Form

Instructions: Obtain statements from the injured employee and any witnesses to include what happened, what caused the incident and what were the contributing factors to the incident. To do this, reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. Provide copies of the completed form and all *Incident Statement Forms* to: agency safety coordinator, the field safety coordinator, supervisor and bureau director or field manager.

Injured Employee Data

Employee Name	Working Title	Personnel Number

Date of Incident	Time of Incident ☐a.m. ☐p.m.	Claim Number (if known)

Work Organization/Location

Supervisor	Supervisor Telephone Number	Supervisor Email

Incident Description:

1. Where did the incident happen and who was involved? Provide a full description of the surroundings of the location and the individuals involved.

2. What was happening at the time of the incident and why was it taking place?

3. What events lead up to the incident? Describe the sequence in order and when they took place.

4. What exactly caused the injury and how did it happen? What mechanics, equipment or tools were involved?

5. Describe the injury. Include the affected body part(s) and injury type or indicate no injury occurred.

6. If a physical injury was avoided, describe what happened that could have potentially resulted in injury?

Additional Information

Provide any additional information important to the investigation (pictures taken, evidence collected).

Initial Investigator:

Incident Investigator Name	Date of Investigation	Time of Investigation ☐a.m. ☐p.m.

CHECK ALL DIRECT CAUSES THAT APPLY

What CONDITION of tools, equipment, or work area contributed to incident? ☐Not Applicable

☐ Close Clearance/Congestion	☐ Floors/Work Surfaces	☐ Poor Housekeeping
☐ Hazardous Placement	☐ Inadequate Ventilation	☐ Equipment Failure
☐ Inadequate Warning System	☐ Inadequate Illumination	☐ Hazardous Materials
☐ Improper Material Storage	☐ Inadequate Guards/Barrier	☐ Defective Tools/Equipment/Vehicle
☐ Inadequate/Improper PPE	☐ Equipment/Workstation Design	☐ Other _______

What ACTION or INACTION contributed to the incident? ☐Not Applicable

☐ Failure to Make Secure	☐ Used Defective Equipment	☐ Failure to Use PPE
☐ Improper Lifting	☐ Improper Technique	☐ Improper Loading
☐ Used Equipment Improperly	☐ Unauthorized Actions	☐ Operating At Improper Speed
☐ Operating Procedure Deviation	☐ Improper Position	☐ Used Wrong Tool/Equipment
☐ Horseplay/Distractive Active	☐ Unsafe Act of Another Staff	☐ Under Influence Drugs/Alcohol
☐ Nullified Safety/Control Devices	☐ Running/Rushing/Acting In Haste	☐ Failure to Warn/Signal
☐ Servicing Equipment In Motion	☐ Other _______	

CHECK ALL UNDERLYING OR ROOT CAUSES THAT APPLY

What caused or influenced the substandard conditions or behaviors?

☐ Lack of Proper Procedures	☐ Inadequate Job Instructions	☐ Inadequate Tools
☐ Inadequate Job Training Methods	☐ Inadequate Supervision	☐ Improper Layout or Design
☐ Inadequate Maintenance Standards	☐ Unsafe Design or Construction	☐ Poor Work Practice
☐ Poor Work Design	☐ Inadequate Purchasing Standards	☐ Lack of Skill
☐ Lack of Communication Between Staff	☐ Improper Extension of Service Life	☐ Improper Planning
☐ Inadequate Cleaning	☐ Inadequate Environmental Controls	☐ Inadequate Capacity
☐ Inadequate Preventive Maintenance	☐ Inadequate Enforcement or Work Standards	
☐ Other ________		

CHECK ALL ACTIONS NECESSARY TO CORRECT THE DIRECT AND ROOT CAUSES

What corrective actions have been taken or are needed to prevent a recurrence?

☐ Task Analysis/Procedure Revision	☐ Improve Clean-Up Procedures	☐ Repair/Replace Equipment
☐ Reinstruction of Employees	☐ Improve Storage/Arrangement	☐ Rotation of Employee
☐ Eliminate Congestion	☐ Improve/Change Work Method	☐ Identify/Improve PPE
☐ Task Analysis to Be Completed	☐ Install/Revise Guards/Devices	☐ Improve Enforcement
☐ Improve Design/Construction	☐ Job Reassignment of Employees	☐ Use Other Materials/Supplies
☐ Improve Illumination	☐ Mandatory Pre-Job Instructions	☐ Improve Ventilation
☐ Other _______		

Recommended corrective actions or preventive measures to be taken

Action Item	Person Responsible	Target Date	Date Complete

Investigation Review (Initial after reviewing the findings of the investigation):

	Initials	Review Date	Comments
Supervisor			
Director/Manager			
Human Resources			
Law Director (If applicable)			
Mayor (If applicable)			