

PROCEDURES TO FOLLOW AFTER A WORK RELATED INJURY OCCURS:

You are required to promptly report all work-related injuries or illnesses to your supervisor.

You or your supervisor will notify HR at (231)591-2150 immediately. Required info: Name of injured, date of injury, type of injury, contact info, and any medical treatment.

Your supervisor is responsible for making sure the "Employee Incident Report" form is completed in detail, with your assistance, within 24 hours and sent to the Office of Human Resources (HR). Both your signature and your supervisor's are required. Your contact person in HR is Mike McKay, Safety Coordinator. Mike is the coordinator of this program and will assist you with forms and any question regarding workers compensation.

You are required to report to the FSU Health Center or other FSU designated clinic for treatment of all non-life-threatening injuries. **Restricted Duty** – Supervisors may modify jobs to accommodate the injured employee and keep them in their home department. If the employee cannot be accommodated in their home department, contact HR and arrangements for a temporary assignment will be made. **Off Work** – It may be necessary in the case of severe disabling injuries for the doctor to excuse you from work. We will work with you to return you to work as soon as medically possible.

Please submit all Medical Excuse/Clearance slip to give to your supervisor. Notify HR and your supervisor of your progress and all future doctor appointments relating to this injury.

Sign an authorization for release of your medical records at each medical facility you visit and have the doctor's reports and bills sent to Ferris. (Please do not pay the bill yourself.) The doctor's report is VERY important; HR cannot submit the worker's compensation claim in for review without it. The medical reports and bills are to be sent to: **Ferris State University, Attn: Human Resources Workers Compensation - Prakken 150, 420 Oak Street, Big Rapids MI 49307-2020.**

Prescriptions are filled through the Health Center. A Mileage Reimbursement form is available to assist you in keeping track of additional trips to doctors and medical facilities that are related to your work injury.

FSU uses a third party administrator to make the determination of compensability under the State Workers' Compensation Act. Prescription and mileage reimbursements will be made after the medical bills that coincide are received. All bills, and reimbursements to you, are paid through the third party administrator. If your workers compensation claim is deemed compensable and you are off work for a minimum of two weeks you are eligible for wage loss benefits. Disability benefits for the time off work are paid at a rate established by the State law. You will not receive full wage for the time off work. However, these payments are tax free, with no deductions for State and Federal taxes, or Social Security.

Instructions for completing an Injury / Illness / Incident Investigation & Report

Report All Injuries to HR at (231)591-2150 Immediately

Forward completed original to: FSU, Human Resources, 420 Oak St. PRK 150, Big Rapids, Mi 49307

1. Print the name of the employee involved in the incident.
2. Enter the employee's identification number.
3. Enter the employee's date of birth.
4. Check the employee's type of employment. If not listed, check "other" and enter description.
5. Enter the employee's home address.
6. Enter the employee's home telephone number. If the employee has no number, enter one where they may be reached.
7. Enter the employee's date of hire.
8. Check the employee's tax filing status.
9. Enter the total number of dependents and the number of dependents under 16 years of age.
10. Check the employee's normal work days.
11. Enter the date which the alleged incident occurred.
12. Check the location of the alleged incident. If not listed, check other and enter description.
13. Enter the department where the employee normally works.
14. Enter the general task of the employee at the time of the alleged incident. (i.e. painter, custodian)
15. Enter the time the alleged incident took place.
16. Enter the general location or building where the alleged incident occurred. (i.e. Prakken, Taggart Hall)
17. Enter the specific location where the alleged incident took place (i.e. Room 201, front steps)
18. Enter the starting time of employee's normal shift.
19. Enter the specific activity the employee was engaged in at the time of the alleged incident (i.e. Hammering, Lifting, Mopping, etc.)
20. Enter the names of the body parts affected (i.e. Left knee, Right hand, Head, Left Foot, etc.)
21. Enter the names of the objects contributing to the alleged incident (i.e. Hammer, mop, floor)
22. Circle the body part(s) affected by the alleged incident.
23. List the causes of the alleged incident (i.e. Slippery floor, loose bolt, improper lifting, etc.)
24. Check the type of injury being described by the employee. If not listed, check "other" and enter the description.
25. Did the incident produce property damage?
26. Was a vehicle involved in the incident?
27. Were proper procedures being used at the time of the alleged incident?
28. Was proper PPE being used at the time of the alleged incident?
29. Was the employee working with a crew or alone?
30. Was the incident a near miss? A near miss incident is an incident that did not produce an injury or illness.
31. List any witnesses and contact info. For serious incidents witnesses must be asked to write out a statement describing the incident in their own words on a separate sheet of paper.
32. The employee writes out their statement describing the alleged incident.
33. The supervisor describes the alleged incident as concluded by his/her investigation.
34. Describe the actions which the employee and/or supervisor have completed to prevent the incident from reoccurring (i.e. Changed process, Retrained employee, Enforced use of proper procedures, etc.)
35. Check the treatment Location
36. Enter the name and contact number of the physician or other health care provider who provided treatment to employee.
37. Enter the name of the health care facility where treatment was provided.
38. Enter the address of the health care facility where treatment was provided.
39. Supervisor prints name and work extension.
40. Supervisor signs the report.
41. The form must be dated the day it was completed.
42. Employee prints full name.
43. Employee signs the report.
44. The form must be dated the day it was completed.

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Distribute copies to the department head, employee and the supervisor.



Ferris State University

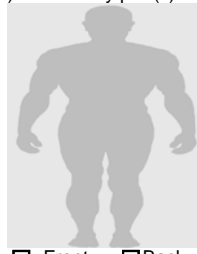
EMPLOYEE INJURY / ILLNESS / INCIDENT INVESTIGATION & REPORT

Report All Work Related Injuries to HR at (231)591-2150 Immediately

Office Use Only:

Rec: Yes No

Rpt. NO. _____

Associate Info	(1) Name of Employee		(2) ID Number		(3) Date of Birth	(4) Employee Type <input type="checkbox"/> AFSCME <input type="checkbox"/> Clerical <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Student <input type="checkbox"/> Other						
	(5) Home Address			(6) Home Phone Number	(7) Hire Date							
	<input type="checkbox"/> Male	(8) Tax Filing Status		(9) Dependents			(10) Work Schedule					
<input type="checkbox"/> Female	<input type="checkbox"/> Single	<input type="checkbox"/> Head of Household	Total	Number Under Age 16	<input type="checkbox"/> Mon	<input type="checkbox"/> Thu						
	<input type="checkbox"/> Married Filing Separate	<input type="checkbox"/> Married Filing Joint			<input type="checkbox"/> Tue	<input type="checkbox"/> Fri						
					<input type="checkbox"/> Wed	<input type="checkbox"/> S <input type="checkbox"/> S						
Location Info	(11) Date of Incident		(12) Campus Location		(13) Department		(14) General Task / Job Classification					
	(15) Time of Incident		<input type="checkbox"/> FSU Big Rapids <input type="checkbox"/> FSU - GR <input type="checkbox"/> Kendall <input type="checkbox"/> Other		(16) General Location / Building		(17) Specific Location of Incident					
	am											
	pm		(19) Specific Activity at Time of Injury or Just Before Injury Occurred									
(18) Start Time of Shift												
am												
pm												
Incident Info	(20) Body Part(s) affected			(21) Object(s) Causing Injury / Illness			(22) Circle body part(s) affected  <input type="checkbox"/> Front <input type="checkbox"/> Back					
	(23) Cause of Injury / Illness or How Injury Occurred											
	(24) Type of Injury / Illness											
	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Contusion/Bruise	<input type="checkbox"/> Rash	<input type="checkbox"/> Other								
<input type="checkbox"/> Amputation	<input type="checkbox"/> Cut / Puncture	<input type="checkbox"/> Repetitive										
<input type="checkbox"/> Bite / Sting	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Respiratory										
<input type="checkbox"/> Burn	<input type="checkbox"/> Fracture	<input type="checkbox"/> Sprain/Strain										
Misc. Info	(25) Property damage		(26) Vehicle involved		(27) Proper procedure used		(28) Proper PPE used for job		(29) Working with		(30) Near Miss	
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Crew <input type="checkbox"/> Alone		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(31) Witness list and Statement											
Employee & Supervisor Description	(32) Employee Statement of Facts											
	(33) Supervisor's Investigation Findings											
Actions Taken	(34) Actions taken to prevent reoccurrence											
Medical	(35) Treatment Location						(36) Physician or other Health Care Professional and Phone Number					
	<input type="checkbox"/> Birkam Health Center <input type="checkbox"/> None						(37) Facility Name and (38) Address					
	<input type="checkbox"/> Off Site Medical Center (complete 36 - 38)											
Employee must:												
A) Return copies of all paperwork from Medical Center to HR												
B) Notify HR of all Medical Treatment												
Signatures	(39) Supervisor (print)				(40) Supervisor (sign)				(41) Date			
	ext. _____											
(42) Employee (print)				(43) Employee (sign)				(44) Date				