PROCEDURES TO FOLLOW AFTER A WORK RELATED INJURY OCCURS:

Employees are required to promptly report all work-related injuries or illnesses to their supervisor.

The employee or supervisor will notify SHERM at (231)591-3848 immediately. Required info: Name of injured employee, date of injury, type of injury, contact info, and any medical treatment provided.

Supervisors are responsible for ensuring the "Employee Incident Report" form is completed in detail, with the assistance of the employee, within 24 hours. The supervisor will send the report to the Office of Safety, Health, Environmental, and Risk Management (SHERM). The complete distribution list is provided on the bottom of the form. The employee's signature and the supervisor's signature are required. The contact person in SHERM is Mike McKay, Director of Safety, Health, Environmental, and Risk Management. Mike is the coordinator of this program and will assist you with forms and any question regarding workers' compensation.

Employees are **required** to report to the FSU Health Center or MED1 Occupational Health 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. Contact SHERM for temporary assignment assistance. **Off Work** – It may be necessary, in the case of severe disabling injuries, for the doctor to excuse employees from work. FSU will work with the employee to return them to work as soon as medically possible.

Submit Medical Excuse/Clearance slips to the supervisor after each appointment. Notify SHERM and the supervisor of progress and all future doctor appointments relating to the injury.

Sign an authorization for release of medical records at each medical facility visited. Request that doctor's reports and bills are sent to Ferris (Please do not pay the bill yourself.) The doctor's report is VERY important; SHERM cannot submit the worker's compensation claim without it. Send medical reports and bills to: **Ferris State University, Attn: Workers Compensation, 1201 S. State St., CSS101U, Big Rapids MI 49307-2020.**

Prescriptions covered under Worker's Compensation are filled through WALGREENS Pharmacy. *Please do not pay the bill yourself* – Ferris is billed directly.

A Mileage Reimbursement form is available to assist you in keeping track of additional trips to doctors and medical facilities that are related to work injuries. All mileage forms must be signed by the medical facility at the time of the visit.

FSU uses a third party administrator to make the determination of compensability under the State Workers' Compensation Act. Prescription payments and mileage reimbursements are made after the medical bills that coincide are received. All bills, and reimbursements, are paid through the third party administrator. If a workers' compensation claim is deemed compensable, a restricted duty assignment is unavailable and the employee is off work for a minimum of eight days; then wage loss benefits are paid. Wage loss benefits for the time off work are paid at a rate established by the State law. The employee does 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. Wage loss payments are made by the third party administrator directly to the employee.

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

Report All Injuries to SHERM at (231)591-3848 Immediately
Forward completed original to: FSU, SHERM, 1201 S. State St., CSS101U, 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.

Forward completed original to: FSU, SHERM, 1201 S. State St., CSS101U, Big Rapids, MI 49307
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 (231)591-3848 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
			☐ AFSCME ☐ Clerical ☐ Faculty ☐ Staff ☐ Student ☐ Other

(5) Home Address	(6) Home Phone Number	(7) Hire Date

	(8) Tax Filing Status	(9) Dependents	(10) Work Schedule
☐ Male ☐ Female	☐ Single ☐ Head of Household ☐ Married Filing Separate ☐ Married Filing Joint	Total _____ Number Under Age 16 _____	☐ Mon ☐ Thu ☐ Tue ☐ Fri ☐ Wed ☐ S ☐ S

Location Info

(11) Date of Incident	(12) Campus Location	(13) Department	(14) General Task / Job Classification
	☐ FSU Big Rapids ☐ FSU - GR ☐ Kendall ☐ Other _____		
(15) Time of Incident am ☐ pm ☐		(16) General Location / Building	(17) Specific Location of Incident
(18) Start Time of Shift am ☐ pm ☐		(19) Specific Activity at Time of Injury or Just Before Injury Occurred	

Incident Info

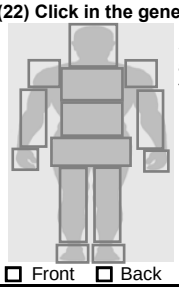
(20) Body Part(s) affected	(21) Object(s) Causing Injury / Illness

(23) Cause of Injury / Illness or How Injury Occurred

(24) Type of Injury / Illness

☐ Abrasion ☐ Amputation ☐ Bite / Sting ☐ Burn ☐ Contusion/Bruise ☐ Cut / Puncture ☐ Dislocation ☐ Fracture ☐ Rash ☐ Repetitive ☐ Respiratory ☐ Sprain/Strain ☐ Other _____ _____

(22) Click in the general effected area(s).



Select the specific area(s) effected from the drop-down menu.

-

Other: _____ _____ _____ _____

☐ Front ☐ Back ☐ Left ☐ Right

Misc. Info

(25) Property damage	(26) Vehicle involved	(27) Proper procedure used	(28) Proper PPE used for job	(29) Working with	(30) Near Miss
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Crew ☐ Alone	☐ Yes ☐ 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 recurrence

Medical

(35) Treatment Location

☐ Birkam Health Center ☐ None

☐ Off Site Medical Center (complete 36 - 38)

Employee must:

A) Return copies of all paperwork from Medical Center to SHERM

B) Notify SHERM of all Medical Treatment

(36) Physician or other Health Care Professional and Phone Number

(37) Facility Name and (38) Address

Signatures

(39) Supervisor (print)	(40) Supervisor (sign)	(41) Date
ext. _____		
(42) Employee (print)	(43) Employee (sign)	(44) Date

Rev. 7/2023

Forward completed original to: FSU - Workers Comp, 1201 S. State St., CSS101U, Big Rapids, Mi 49307 (231)591-2978 fax

cc: ☐ Department Head ☐ Employee ☐ Supervisor

(231)591-3848 or (800)592-6499 ext. 3848