



# PORTAGE COUNTY

## WORKER'S COMPENSATION REPORTING GUIDELINES

### **MANDATORY FOR ALL WORK-RELATED INJURIES**

Contact the County Mutual Care Line™ to report your injury to the Care Line Nurse immediately by calling **(855) 650-6580**

### **PORTAGE COUNTY WORKER'S COMPENSATION EMPLOYEE INCIDENT REPORT**

Complete all sections of this report. Be clear and precise when describing how the injury occurred and what body parts were affected and how they were affected. Submit to your immediate supervisor.

### **SUPERVISOR'S INCIDENT INVESTIGATION REPORT**

This section is to be completed by your Supervisor. Supervisors forward entire report to the Department Head and Risk Management office within 24 hours.

### **ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD**

If you seek medical attention for a work-related injury or illness, this form, or a similarly detailed form from your medical provider's office, must be completed, appropriately signed, dated, and submitted to your supervisor immediately.

It is the employee's responsibility to –

- 1) Obtain proper signatures on ALL return to work forms.
- 2) Advise your physician that restricted duty assignments **will** be made available and followed according to your physician's orders.
- 3) Provide a return to work form to your supervisor **after each** medical appointment.
- 4) Know that physician's slips taking you **off work** or issuing **restrictions** are **only acceptable** when –
  - a. Signed by a **physician, chiropractor, psychologist, dentist or podiatrist** licensed to practice in the state of Wisconsin.
  - b. The slip is issued on the same date as your appointment. Back-dated slips will not be accepted.
- 5) **Understand that Worker's Compensation benefits will not be paid if non-compliant with #3 and #4, above.**
- 6) Review your physician's restrictions before leaving your appointment. If there are any work assignments that need to be clarified, ask your physician to make a notation on the return to work form. (Example: If you are unable to climb, reach or pull, but are allowed to drive a truck, ask your physician to indicate on the form whether or not you can "pull" yourself up and "climb" into the truck's cab.)
- 7) **Know that you will be asked to provide proper documentation, as stated in items #1-6 above, before work assignments will be issued.**

**IMPORTANT  
READ 3 & 4  
CAREFULLY**

### **WITNESS STATEMENT**

Each witness to this incident must complete a Witness Statement. Provide a copy to each Witness listed on the Incident Report.

### **Voluntary and Informed Consent for Disclosure of Health Care Information** (2 pages)

Complete this form for each Medical Provider or Clinic where you've been treated for this injury/illness. Provide your signature on **both** pages and return same to your supervisor.

### **MILEAGE / OUT-OF-POCKET EXPENSE REIMBURSEMENT FORM**

Complete this form and provide required support documentation in order to be reimbursed for mileage to and from medical appointments and out-of-pocket expenses for *prescribed* medications/equipment.

### **BILLING INFORMATION & CLAIMS ADJUSTER**

*Provide this billing information to all service providers.*

AEGIS CORPORATION  
P.O. Box 123  
Milwaukee, WI 53201  
Phone: (800) 236-6885  
FAX: (262) 252-6579  
Claims Adjuster: JEFF ROYTEN

### **PORTAGE COUNTY RISK MANAGEMENT**

*Contact with questions about your claim.*

COLLEEN BRANDT, Risk Management Specialist  
1462 Strongs Avenue  
Stevens Point, WI 54481  
Phone: (715) 346-1489  
FAX: (715) 346-1634  
Email: [riskmanagement@co.portage.wi.us](mailto:riskmanagement@co.portage.wi.us)

### **SUMMARY of WORKER'S COMPENSATION BENEFITS\***

**MEDICAL** – If your injury or illness is compensable under the law, costs for reasonable and necessary medical treatment will be paid.

**COMPENSATION** – If your physician assesses temporary disability, authorizes time off work or restricts the number of hours you can work, you *may* be entitled to compensation. NOTE – 1) the first 3 days following an injury are *not* compensable unless you miss work beyond the 7<sup>th</sup> calendar day following the injury, 2) compensation begins the 4<sup>th</sup> day of lost time, and 3) benefits are approximately 2/3 of your weekly gross wages. For these reasons, you may choose to use earned benefits to avoid a reduction in pay in these situations.

Lost time from work to attend medical appointments, including physical therapy, is *not* compensable when appointments can be made outside of working hours. If you are unable to schedule appointments outside of working hours, contact the Claims Adjuster named above. The adjuster, or their designee, will work with you and your medical provider to obtain appointments outside of working hours.

**EXPENSES** – Mileage to and from medical appointments is reimbursable. Out-of-pocket expenses for medications and/or equipment prescribed by your physician are reimbursable when proper documentation is submitted to the Claims Adjuster.

*\*This summary is a non-exhaustive explanation of Worker's Compensation benefits. Full details can be found at - <https://dwd.wisconsin.gov/wc/workers/>*

### **WORKER'S COMPENSATION FRAUD**

It is a **felony** for anyone to knowingly file a false or fraudulent claim for the purpose of obtaining Worker's Compensation benefits.

Anyone found guilty of performing this illegal act will be prosecuted to the full extent of the law. If convicted, the person could face up to 2 years in prison and/or a fine up to \$10,000.

**EMPLOYEE INFORMATION**

**TO BE COMPLETED BY THE INJURED EMPLOYEE**

NAME:  SSN:  BIRTH DATE:  HIRE DATE:

ADDRESS:  CITY:  STATE:  ZIP:

HOME PHONE NUMBER:  ALTERNATE PHONE NUMBER:

**EMPLOYMENT HISTORY**

OCCUPATION:  DEPARTMENT:

NORMAL WORK SCHEDULE:	Start Time	Hrs/Day	Hrs/Week	Days/Week
	AM PM			

**ACCIDENT INFORMATION**

DATE OF INJURY:  TIME OF INJURY:   A.M.  P.M.

DID INJURY OCCUR DURING NORMAL WORK SCHEDULE?

NAME OF INDIVIDUAL TO WHOM INJURY WAS REPORTED:  DATE REPORTED:

LOCATION OF INCIDENT:

INCIDENT DESCRIPTION:  
Explain, in detail, what you were doing immediately before the incident and how the incident/injury occurred.

INJURY DESCRIPTION - be specific (top left side of head, right side of neck, center of lower back, left eyelid, right index finger)

INCLUDE:  
ALL BODY PARTS AFFECTED  
SYMPTOMS FOR EACH BODY PART  
WHAT CAUSED THE INJURY?

WITNESS(ES) - NAMES AND PHONE NUMBERS:

DID/WILL YOU SEEK MEDICAL TREATMENT?

IF YES, PLEASE PROVIDE PHYSICIAN INFORMATION:

CLINIC	<input type="text"/>
PHYSICIAN	<input type="text"/>
ADDRESS	<input type="text"/>
PHONE	<input type="text"/>

**READ BEFORE SIGNING:** I hereby certify that the content in this report is true and correct to the best of my knowledge. I further understand that it is a **felony** for anyone to knowingly file a false or fraudulent claim for the purpose of obtaining Worker's Compensation benefits, and that anyone found guilty of performing this illegal act will be prosecuted to the full extent of the law; if convicted, the person could face up to 2 years in prison and/or a fine up to \$10,000.

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 - unable to accommodate

PLEASE SUBMIT REPORT TO:

COUNTY	PORTAGE COUNTY
EMAIL	riskmanagement@co.portage.wi.us
PHONE	715-346-1489
FAX	715-346-1634

ADDITIONAL COMMENTS:

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:

**SUPERVISOR'S INCIDENT INVESTIGATION REPORT**

**TO BE COMPLETED BY THE SUPERVISOR**

NAME OF INJURED PERSON:  TODAY'S DATE:  CHECK ONE  
 EMPLOYEE  VOLUNTEER

NAME AND POSITION OF PERSON PREPARING REPORT:

DEPARTMENT:  SUPERVISOR'S PHONE NUMBER:

INCIDENT DATE:  TIME OF INCIDENT:  AM.  
 P.M. LEFT WORK?

LOCATION OF ACCIDENT:

EMPLOYEE'S HOURLY RATE AT TIME OF INJURY:

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

UNSAFE ACTS	<input checked="" type="checkbox"/>	ADD DETAIL	UNSAFE CONDITIONS	<input checked="" type="checkbox"/>	ADD DETAIL
IMPROPER WORK TECHNIQUE			POOR WORKSTATION DESIGN		
SAFETY RULE VIOLATION			UNSAFE OPERATION METHOD		
IMPROPER PPE OR PPE NOT USED			IMPROPER MAINTENANCE		
OPERATING WITHOUT AUTHORITY			LACK OF DIRECT SUPERVISION		
FAILURE TO WARN OR SECURE			INSUFFICIENT TRAINING		
OPERATING AT IMPROPER SPEEDS			LACK OF EXPERIENCE		
BY-PASSING SAFETY DEVICES			INSUFFICIENT KNOWLEDGE OF JOB		
PROTECTIVE EQUIPMENT NOT USED			SLIPPERY CONDITIONS		
IMPROPER LOADING OR PLACEMENT			EXCESSIVE NOISE		
IMPROPER LIFTING			INADEQUATE GUARDING OF HAZARDS		
SERVICING MACHINERY IN MOTION			DEFECTIVE TOOLS / EQUIPMENT		
HORSEPLAY			POOR HOUSEKEEPING		
INSUFFICIENT LIGHTING			OTHER (PLEASE LIST)		

HOW COULD THIS ACCIDENT HAVE BEEN PREVENTED?

CORRECTIVE ACTION TAKEN BY SUPERVISOR? (CLICK)

REINSTRUCTION/RETRAINING OF PERSON INVOLVED?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
EQUIPMENT REPAIR/REPLACEMENT?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
IMPROVED PERSONAL PROTECTIVE EQUIPMENT?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
REDUCED CONGESTION?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
IMPROVED DESIGN/CONSTRUCTION?	<input type="button" value="YES"/>	<input type="button" value="NO"/>
DISCIPLINE OF PERSON INVOLVED?	<input type="button" value="YES"/>	<input type="button" value="NO"/>

DATE CORRECTIVE ACTION WAS TAKEN:

OTHER:

IN DETAIL, PLEASE EXPLAIN ACTION TAKEN TO PREVENT RECURRENCE:

IS A SAFETY REVIEW REQUESTED?

SUPERVISOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 (IF INCIDENT INVOLVED A SAFETY VIOLATION / CORRECTIVE ACTION)

**ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD**

EMPLOYER NAME:   
 CLAIM NUMBER:

PATIENT NAME:  DATE OF INJURY:

TO BE COMPLETED BY **ATTENDING PHYSICIAN**

DIAGNOSIS/CONDITION  
(BRIEF EXPLANATION)

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

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

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

**SEDENTARY WORK.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS:

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

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

NAME OF PROVIDER:  PHONE #:   
 PHYSICIAN:   
**PHYSICIAN'S SIGNATURE:**  DATE:



## PORTAGE COUNTY WITNESS STATEMENT

You were named as a Witness to a work-related incident involving the individual named below.  
Please complete this form, providing as much detail as you are able, and return within 24 hours to –

Portage County Risk Management  
Courthouse Annex  
1462 Strongs Avenue  
Stevens Point, WI 54481

Email - [brandtc@co.portage.wi.us](mailto:brandtc@co.portage.wi.us)

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INJURED EMPLOYEE \_\_\_\_\_ INCIDENT DATE \_\_\_\_\_ TIME OF INJURY \_\_\_\_\_  AM  
 PM  
WITNESS NAME \_\_\_\_\_ WITNESS JOB TITLE \_\_\_\_\_  
INCIDENT LOCATION \_\_\_\_\_

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IF THE DATE, TIME OR LOCATION SHOWN ABOVE ARE INCORRECT, PLEASE PROVIDE CORRECTIONS HERE.

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WERE YOU PRESENT AT THE TIME OF THE INCIDENT?  YES  NO DID YOU SEE THE INCIDENT OCCUR?  YES  NO

PROVIDE DETAILS ABOUT WHAT YOU OBSERVED BEFORE THE INCIDENT, AND WHEN THE INCIDENT OCCURRED.

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DID YOU SEE THE INJURED EMPLOYEE WEARING OR USING SAFETY EQUIPMENT AT THE TIME OF THE INCIDENT?  YES  NO

IF YES, WHAT SAFETY EQUIPMENT WAS THE EMPLOYEE USING?

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I HAVE CAREFULLY REVIEWED THE INFORMATION CONTAINED IN THIS WITNESS STATEMENT. TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE AND ACCURATE STATEMENT OF RECOLLECTION OF THE EVENT.

WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# Voluntary and Informed Consent for Disclosure of Health Care Information

\*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.  
 Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

**Department of Workforce Development  
 Worker's Compensation Division**  
 201 E. Washington Ave., Rm. C100  
 P.O. Box 7901  
 Madison, WI 53707  
 Telephone: (608) 266-1340  
 Fax: (608) 267-0394  
<http://www.wisconsin.gov/wc/>  
 e-mail: [DWDDWC@dwd.wisconsin.gov](mailto:DWDDWC@dwd.wisconsin.gov)

By law, all health care providers must provide to 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.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Provider Name		Street Address	
P.O. Box	City	State	Zip Code
Patient (Employee) Name		Employer Name	
Patient Social Security Number*	Patient Birth Date	WC Claim No.	

The patient named above hereby authorizes 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 and Address of Party Authorized to Receive Protected Information <b>AEGIS CORPORATION, P.O. BOX 123, MILWAUKEE, WI 53201</b>
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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.

**CHECK ONE:**

- A. 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 any 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. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.
- B. Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any 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 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.

Patient Signature (or Person Authorized to Sign for Patient) – for Option B
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Patient Signature (or Person Authorized to Sign for Patient)	Date Signed
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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 written request to the party authorized above to receive information. However, I understand that my revocation is not effective with respect to actions a covered entity took in reliance on this authorization or as needed for an insurer to contest a claim/policy authorized by law if signing the authorization was a condition to obtaining insurance coverage.
- I may obtain a copy of the disclosed 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 or 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.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

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 it must be used within a certain number of days after the date of signing, or that it 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 copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient):	Date Signed
If not signed by patient, authority/designation to sign is based on the fact that the patient is: <input type="checkbox"/> A minor <input type="checkbox"/> Incompetent <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased <input type="checkbox"/> Other:	

