What to do in the event of an On-The-Job Injury/Incidents

Employee Instructions

Please report on-the-job injuries/incidents as soon as reasonably possible or by the end of the shift in which the injury/incident occurred. On-the-job injuries/incidents should be reported on the City of Charleston Report of Incident and Injury form. On-the-job injuries/incidents not reported in accordance with City policy may impact on the status of your claim, including the delay or denial of your claim/benefits.

When an on-the-job injury occurs, immediately notify your supervisor and/or Department Head. If your supervisor and/or Department Head is unavailable, notify the Safety Coordinator in the Human Resources Department at (304) 348-8015.

Submit your completed Report of Incident and Injury Form and Workers Compensation TTD Benefits or Sick Leave Election of options form to the Safety Coordinator.

If the injury is not an emergency or life threatening, employees are encouraged to seek medical treatment at an urgent care facility. The City of Charleston Employee Wellness Center DOES NOT see or treat employees who have sustained an on-the-job injury.

If you desire to seek medical treatment, you should take a Transitional Duty Evaluation Form and attach letter with you on your initial visit with your treating physician. Request that your physician complete and return the Transitional Duty Evaluation Form to the Safety Coordinator at fax number (304) 348-8055.

Employees should contact the Safety Coordinator at (304) 348-8015 in order to provide an update with respect to the extent of his/her injury, return-to-work status, next appointment, etc.

Please submit copies of all documents/forms from your treating physician's visits related to your on-the-job injury to the Safety Coordinator by secure fax at (304) 348-8055.

If you have any questions, please feel free to contact the Safety Coordinator at (304) 348-8015.

CITY OF CHARLESTON
Report of Incident and Injury

General Information

Employee Name: _____ **Employee No.:** _____

Department: _____ **Position:** _____

Supervisor: _____ **Incident Date & Time:** _____ _____ _____

Address/Location of Incident: _____

Describe what the employee was doing immediately prior to the incident:

_____

Date & Time Employee Shift Began: _____ _____

Incident Details

What equipment, substance or other object caused the incident:

_____

Name of individual(s) first notified: _____

List the name(s) of any witness* _____

Incident Date & Time: _____ _____ _____

*Attach witness statement for each witness

Check Body Part(s) or Area(s) affected and indicate right,left, or both, if applicable): (Check all that apply)

- ☐ Ankle
- ☐ Arm
- ☐ Chest
- ☐ Elbow
- ☐ Eye
- ☐ Face
- ☐ Finger
- ☐ Foot
- ☐ Groin
- ☐ Hand
- ☐ Head
- ☐ Hip
- ☐ Internal
- ☐ Knee
- ☐ Leg
- ☐ Lower Arm
- ☐ Lower Back
- ☐ Lower Leg
- ☐ Neck
- ☐ Respiratory
- ☐ Shoulder
- ☐ Thumb
- ☐ Toes
- ☐ Trunk
- ☐ Upper Arm
- ☐ Upper Back
- ☐ Upper Leg
- ☐ Wrist
- ☐ Other (describe below)

_____

Injury Source: (Check all that apply)

- ☐ Automobile Accident
- ☐ Burn
- ☐ Caught In/Under/Between
- ☐ Cut / Puncture / Laceration
- ☐ Electric Shock
- ☐ Equipment Accident
- ☐ Fall
- ☐ Hand Tool(s)
- ☐ Injured by Animal/Insect
- ☐ Machine Injury
- ☐ Material Handling
- ☐ Portable Power Tool(s)
- ☐ Repetitive Motion
- ☐ Slip or Trip
- ☐ Sprain / Strain
- ☐ Struck By/Against/Object
- ☐ Struck By/Against/Person
- ☐ Other (describe below)

_____

Treatment

Medical Treatment: (Check one)

☐ On-site First-aid only ☐ Urgent Care Facility ☐ Emergency Room ☐ Other (describe below)

_____

Name and location of medical facility (enter N/A if employee received no treatment):

_____

Was the employee admitted to the medical facility?

Preparer's Name (print):_____ **Preparer's Signature:**_____**Date:**_____

Employee's Signature:_____ **Date:**_____

By signing above, the employee does hereby authorize any person or persons who have in the past, or will in the future medically amend, treat or examine me or any person who may have information of any kind which may be used to arrive at decision in any claim for injury or disease arising from the injury/illness described above, to disclose such information to the City, or any individual or entity authorized by the City. A copy of this form shall also serve as an original.

A completed report must be sent to the Safety Coordinator no later than the end of the shift in which the incident/injury occured, or a soon as reasonably possible if off-site medical treatment was obtained. Completed forms can be faxed to (304) 348-8055 or emailed to adam.simon@cityofcharleston.org

Revised 11/2024

CITY OF CHARLESTON
Statement of Witness to Incident

Section I: Incident Identifying Information

Name of Employee Involved in Incident:

Department: Select Department **Date of Incident:**

Section II: Witness Statement Name:

Phone No.:

Address:

City: **State:** **Zip:**

Did you observe an incident involving the employee referenced in Section I above? ☐ **Yes** ☐ **No**

If "Yes", what was the date and time of the incident? Select AM/PM

If "Yes", described what you observed:

If you checked "No" above, how did you learn about the incident?

Name of Witness (please print)

Signature **Date**

Revised 01/05/2017

WORKERS COMPENSATION TEMPORARY TOTAL DISABILITY BENEFITS OR SICK LEAVE BENEFITS

Employee Name: _____ Position Title_____

Date of Injury: _____ Claim # (if known) _____

Department: _____ Supervisor: _____

To the Employee: Please submit this completed form to the Safety Coordinator.

If you are on the job injury will result in you missing three (3) or fewer consecutive scheduled workdays, you are not eligible to receive temporary total disability (TTD) benefits (i.e. wage replacement). However, any medical expenses incurred or any treatment of covered conditions as a result of the injury, if any, will be paid. Should your on the job injury result in you missing more than seven (7) consecutive scheduled work days, you may be eligible for Workers Compensation wage replacement beginning the date of injury, if eligible and approved.

If you are absent from work due to a work related injury, you must choose to receive either Temporary Total Disability benefits (TTD benefits) from Workers Compensation or paid sick or vacation leave TTD benefits, you may use sick leave until you receive your initial TTD benefit check; however, this leave will be restored when you reimburse the City the net value of the paid sick leave used, according to the provisions of this policy.

___ Option 1

I elect to receive Workers Compensation TTD benefits; however, I understand that I may use sick leave and or vacation leave only until I receive my initial TTD benefits check. I understand that while receiving TTD benefits, I will be in a leave of absent without pay status. During this leave of absence without pay, I understand that I will accrue vacation leave. I will not accrue sick leave and I will not be paid for holidays during this leave of absence without pay.

___ Option 2

I elect to receive sick leave and or vacation leave benefits instead of Workers Compensation TTD benefits for the period that I am absent from work due to a work-related injury. While I am receiving paid leave benefits, I understand that I will continue to accrue vacation leave, sick leave, and be paid for holidays that occur during this period. After I exhaust my sick leave and or vacation leave, I understand that I am eligible to receive my TTD benefits during any remaining period of absence from work due to me compensable injury. If I receive TTD benefits, I understand that while receiving these benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will accrue vacation leave. I will not accrue sick leave and I will not be paid for holidays during this leave of absence without pay.

Employee's Statement: I understand that I must choose either Workers Compensation TTD benefits or paid sick leave and or annual leave, that I am not legally entitled to both for the same period. I understand that if I elect to receive TTD benefits and choose to receive paid sick leave and or annual leave until I receive TTD benefits check, I must reimburse the net value of the paid leave to my employer, who will then restore that leave. If I fail to reimburse my employer the net value of the paid leave used, I understand such amount will be deducted from future wage payments.

Employee's Signature: _____

Date Submitted: _____

encova INSURANCE

WEST VIRGINIA WORKERS' COMPENSATION EMPLOYEES' AND PHYSICIAN'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

For Encova use only

Claim number:

Team assigned:

SECTION I - EMPLOYEE'S CLAIM INFORMATION

1. Last name	First name		MI
2. Address			3. Telephone
City	State	ZIP	4. Social Security number
5. Date of birth	6. Sex ☐ M ☐ F		7. Marital status
8. Date of injury or last exposure	Time ☐ a.m. ☐ p.m.		9. Time you began work on date of injury ☐ a.m. ☐ p.m.
10. Date you stopped working due to injury			
11. Have you retired? ☐ Yes ☐ No	If "yes," what was the date you retired?		
12. Employer's name		Supervisor's name	
Address			
City	State	ZIP	Telephone
13. Job title/description			
14. Body parts injured			
15. Describe how your injury occurred (specify the cause, what you were doing and equipment/objects involved):			
16. Did injury occur on employer's property? ☐ Yes ☐ No Address where injury occurred			
17. Please identify any witnesses to your injury			

I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I hereby authorize any physician, chiropractor, surgeon, practitioner or other health care provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be valid as the original.

Employee's signature | Date

SECTION II - ALL INFORMATION MUST BE COMPLETED BY INITIAL PROVIDER

1. Name of physician/hospital		2. FEIN/Social Security number	
3. Address			
City	State	ZIP	Telephone
4. Date of initial treatment		5. Date patient may return to work	
6. Have you advised the patient to remain off work four or more days? ☐ Yes If yes, indicate dates from to ☐ No If no, is the patient capable of ☐ Full duty ☐ Modified duty If the patient is capable of returning to modified duty, specify any limitations/restrictions			
7. Condition is a direct result of ☐ Occupational injury? ☐ Occupational disease? ☐ Non-occupational condition?			
8. Did this injury aggravate a prior injury/disease? ☐ Yes ☐ No		If "yes," explain	
9. Description of injury or occupational disease			
10. Body part(s) injured		11. ICD10-CM diagnosis code(s) in order of severity	
12. Name of physician referred to		13. If the patient was hospitalized, where?	

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge I have been informed of my responsibilities under West Virginia Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Physician's signature | Date

encova INSURANCE

MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to _____ (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

HIV/AIDS	Behavioral health	Drug and alcohol	Genetic history
_____	_____	_____	_____

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ Signature of individual

_____ Date

_____ Social Security number

_____ Date of birth

_____ Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

City Of Charleston

Fax to 304-348-8055

TRANSITIONAL DUTY EVALUATION FORM - *To Be Completed by Attending Physician*

Patient's Name	(Last)	(First)	(M.I.)
Date of Initial Injury/Illness		Date of Treatment	
Brief Explanation of Diagnosis/Condition			

Based on the above description of the patient's current medical problem, I recommend the following:

☐ Patient may return to work with **no limitations**	On this Date:
☐ Patient may return to work **with limitations** (listed below)	On this Date:

Check all that apply as they relate to the above condition:

☐	**Sedentary Work** – Lifting 10 lbs maximum and occasionally lifting or carrying such articles as dockets, ledgers and small tools. Work essentially involves sitting and is considered sedentary if only a small amount of walking and standing is necessary to carry out duties.	**1.**	In an eight hour work day, 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
☐	**Light Work** – Lifting 20 lbs maximum and frequent lifting or carrying of objects up to 10 lbs. Work is classified as light if it requires walking or standing to a significant degree (regardless of weight lifted) or involves sitting most of the time with a degree of pushing and pulling of arm or leg controls.	**2.**	Patient may use hand(s) for repetitive: ☐ Single Grasping ☐ Fine Manipulation ☐ Pushing/Pulling
☐	**Light-Medium Work** – Lifting 30 lbs maximum and frequent lifting or carrying of objects weighing up to 20 lbs.	**3.**	Patient may use foot/feet for repetitive movement, as in operating foot controls. ☐ YES ☐ NO
☐	**Medium Work** – Lifting 50 lbs maximum and frequent lifting or carrying of objects weighing up to 25 lbs.	**4.**	Patient may (fill in as needed, including any other instructions / limitations or prescribed medications):
☐	**Light-Heavy Work** – Lifting 75 lbs maximum and frequent lifting or carrying of objects weighing up to 40 lbs.		
☐	**Heavy Work** – Lifting 100 lbs maximum and frequent lifting or carrying of objects weighing up to 50 lbs.		
Do these restrictions apply to activities outside of working hours? YES NO If no, explain:			

☐ These restrictions are in effect until (date):	☐ Or until patient is re-evaluated on (date):

☐ **Patient is totally incapacitated at this time, and a re-evaluation is scheduled on (date):**

Referred To: ☐ None	☐ Private Physician	☐ Return Here	☐ A Consultant	☐ Other (specify):
Physician's Signature				Date

Patient's Authorization to Release Information: I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of my examination or treatment for the injury identified above to my employer or representative.

Patient/Employee's Signature	Date

Revised July 2016

CITY OF CHARLESTON
OFFICE OF HUMAN RESOURCES
P.O. BOX 2749
CHARLESTON, WV 25330
(304) 348-8015

Letter To Treating Physician

Re: Transitional Duty Evaluation Form

Dear Medical Provider:

You are currently treating a valuable employee of the City of Charleston (the "City") for an on-the-job injury/illness. The city maintains a Return-To-Work program which is designed to assist an injured employee in the transition to his/her normal work assignment as soon as medically possible.

We may be able to accommodate any restrictions you believe are medically necessary to ensure a smooth transition and full recovery, including, but not necessarily limited to modified duties/responsibilities, work hours and/or other accommodations for the continuation of medical treatment during recovery.

Please complete the attached Transitional Duty Evaluation Form which describes the restrictions, if any, you believe are medically necessary to our employee's recovery. The City's objective is to return the employee to his/her pre-injury work assignment, and we ask that you keep this objective in mind when establishing a treatment plan and/or restrictions. You may return the completed form to us via our secure fax line at (304) 348-8055.

Should you have any questions, or need any further information, please contact me at (304) 348-8015. Thank you for your attention and cooperation.

Sincerely,

Adam Simon
Safety Coordinator
City Of Charleston

Mitchell ScriptAdvisor

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by **Encova Insurance** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **present it at the pharmacy** at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Attention Pharmacists: **Process through Script Care and Enter RxBIN, RxPCN and GROUP.**

Member Name:

Member ID #:

Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001536TC

Walmart · RITE AID · Longs Drugs · CVS pharmacy · TARGET · Walgreens · SAFEWAY

Questions?
Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

mitchell

Mitchell International
866.221.6588

INJURED EMPLOYEE CHECKLIST

- [ ] Report all injuries to supervisor

  (Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)

- [ ] Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)

- [ ] If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form

- [ ] If not released to return to work, you must call your supervisor within one business day and provide:
  - Physician's name, address and phone number
  - Date of your next scheduled doctor appointment

- [ ] Return Incident Report to your supervisor upon return or within 24 hours