

**WALWORTH COUNTY WORKER'S COMPENSATION
SUPERVISOR INSTRUCTION PACKET**

Your employee has reported an injury or illness to you that they claim is work related. As the supervisor you will need to follow up on this report. This packet is designed to help you through this process. Attached you will find:

Supervisor's Analysis of Work Injury/Illness
Employer's First Report of Injury or Disease (WKC-12)

Instructions:

1. You will need to provide your employee with the Worker's Compensation Paperwork Procedures-Instructions for Employees. Advise the employee that you will want to review their injury report as soon as possible, preferably before they leave work at the end of their shift, but always within 24 hours or the next business day.
2. You need to complete the Supervisor's Analysis of Work Injury/Illness within 24 hours of receiving the employee's report of injury/illness. Be thorough; meet with the employee to discuss their report of injury/illness, talk with any identified witness, tour the accident area and look over any equipment that may have been involved.
3. Either you or the staff responsible within your department for Worker's Compensation reporting need to forward a WKC-12 to the Human Resources Department within 24 hours of the employee's notification of injury/illness. Keep in mind: THE WKC-12 IS NEVER COMPLETED BY THE CLAIMANT.
4. Your employee will be bringing you a medical certification form after each visit to their medical provider. This form will provide you information on their progress, restrictions for "light-duty" assignments, etc. You need to keep a copy for your records, and forward the original to Human Resources within 24 hours of receipt.
5. Any medical bills received by the employee related to their injury should be forwarded to the Human Resources Department.
6. Any questions? Feel free to contact Human Resources at (262) 741-7950.

**WALWORTH COUNTY
WORK INJURY/ILLNESS REPORT
TO BE COMPLETED BY SUPERVISOR**

Employee Name		Date of Injury	Department
When was this accident reported to you and by whom?		Have you reviewed the Employee Statement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Did you discuss the Incident with the Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Did you tour the area? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is the Incident Questionable? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What were the results of your interview with the witness(es)?		Did you obtain statement(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the employee's description of the accident concur with the witness(es)? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, explain.			
What are the specific causative factors in this accident?			
Were any safety rules violated? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, which rules?			
What are the specific recommendations you would make in order to prevent this type of accident from recurring?			
Would the employee benefit from any type of training? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Scheduled Training: _____ If so, what training?			
EQUIPMENT Is there a repair order for the equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No		When was it prepared?	Who was it submitted to?
Date of follow-up with employee and/or equipment order			
Supervisor Signature			Date Signed

**RETURN COMPLETED FORM TO:
Walworth County Human Resources
(262) 741-7950 PHONE
(262) 741-7948 FAX**

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

**Department of Workforce Development
Worker's Compensation Division**
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

The provision of your social security number 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)]. **(Please read the instructions on page 2 for completing this form)**

EMPLOYEE	Employee Name (First, Middle, Last)		Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Home Telephone No. () -	
	Employee Street Address		City	State	Zip Code	Occupation
	Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?			
EMPLOYER	Employer Name Walworth County		WI Unemployment Ins. Acct No. 692062	Self-Insured? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Nature of Business (Specific Product) County Government	
	Employer Mailing Address P.O. Box 1001		City Elkhorn	State WI	Zip Code 53121 -	Employer FEIN 39-6005752
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer Wisconsin Municipal Mutual Insurance Company					Insurer FEIN 52-1546060
	Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer: WMMIC 4785 Hayes Road, Madison, WI 53703					TPA FEIN 52-1546060
WAGE INFORMATION	Wage at Time of Injury \$	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) if Employee Received:	<input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. \$	
	Is Worker Paid for Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, After How Many Hours of Work Per Week?					
	For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.					
	No. of Weeks:	Gross Amount Excluding Tips: \$		If Piece-Work, No. of Hrs. Excluding Overtime:		
	Employee's Usual Work Schedule When Injured:		Start Time : <input type="checkbox"/> AM <input type="checkbox"/> PM	Hours Per Day	Hours Per Week	Days Per Week
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:						
INJURY INFORMATION	Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			Number of Full-Time Employees Doing The Same Type Of Work:	
	Injury Date	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return	
	Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death	Was This a Lost Time or Other Compensable Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury Occur Because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules		
	Was Employee Treated in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Employee Hospitalized Overnight as an In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Name and Address of Treating Practitioner and Hospital: Case Number from the OSHA Log:					
Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.						
What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)						
What Was the Injury or Illness? (State the Part of Body Affected and How It Was Affected)						
Report Prepared By		Work Phone Number () -	Position		Date Signed	

WKC-12-E (R. 11/2005)

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.