

On-The-Job Injury Instructions

If you have an on-the-job injury, the following actions are required:

1. **Reporting Incident/Injury:**
 - a. Notify supervisor and Medical Management (304.293.HURT) that an injury has occurred ***within 24 hours***.
 - b. Complete supervisor's injury/illness report and return within 3 days. Original should be mailed to EH&S and a copy should be faxed to Medical Management (304.293.2644).
 - c. It is the supervisor's responsibility to complete steps a & b if employee is unable.
 - d. **Steps a & b need to be completed even if you do not seek medical treatment.**

2. **Seeking medical treatment, filing under Workers' Compensation:**
 - a. Notify the treating physician that you have sustained an on-the-job injury.
 - b. Ensure that you complete the WC-1 & 2 form at treating physicians office (Zurich North America is our WC Carrier). It is recommended that you file the claim as close to your injury date as possible.

3. **Release:** A release from your physician must be provided to **Medical Management before** going back to work, regardless of the amount of time missed.

4. **Extended Medical Leave/Completion of Medical Verification Leave Form:**
 - a. This form is required when you are absent from work for more than 5 consecutive days. Upon completion, it can be delivered or faxed to: Medical Management, One Waterfront Place, Fax: 304.293.2644
 - b. Your diagnosis, prognosis, and duration of time that you will be off work must be indicated by your treating physician on this form.
 - c. If authorized, you will receive a letter from Medical Management providing the dates of your medical leave. Your supervisor and EBO will receive a copy of this letter by email.
 - d. A release from your physician must be provided to **Medical Management before** going back to work.

5. **Return to Work with Restrictions:** If you are released to return to work with restrictions, you are required to provide written medical information that clearly defines your restrictions. Medical Management will work with your department to determine if your position may be modified to meet your restrictions on a temporary basis. If so, a Transitional Return to Work Agreement will be forwarded to your department for signatures. A position can be modified for a maximum of 6 months. If modifications cannot be made, you will continue on an authorized medical leave of absence.

6. **Option Election Form:**
 - a. When Medical Management is notified that you have filed a Workers' Compensation Claim, you will be sent an Option Election Form, if you are a leave eligible employee.
 - b. If you have questions relative to this form, contact Amanda Biddle at 304.293.HURT.

7. **Witness Statement:** A witness to an on-the-job injury who wishes to submit a statement should complete the Witness Statement Form. The form should be sent along with injury report, it then will be forwarded to Zurich.

Notify, within 24 hours, Environmental Health and Safety (EHS) (304-293-3792) and Medical Management (304.293.HURT) that an injury has occurred. **Supervisors** complete this form and send to EHS within **3 days** of an injury.

For EH&S use only	OSHA Recordable <input type="checkbox"/> Yes <input type="checkbox"/> No	Reclassified <input type="checkbox"/>	Privacy Case <input type="checkbox"/>	Serious Injury <input type="checkbox"/> Fatality <input type="checkbox"/>
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SECTION ONE

1. Name of Injured: _____ 2. WVU ID No. (700 xx xxxx): _____
 (Last, Suffix) (First) (Middle) [Click here to look up WVU ID](#)

3. Gender: Female Male 4. Date of Birth ____/____/____ 5. Date of Incident ____/____/____

6. Time of Incident: ____:____ AM ____:____ PM during work entering work leaving work lunch/break

7. Campus: Main Potomac WVUIT 8. Department _____ 9. Job Title _____

10. Employment Category: (Check one) Faculty Staff Student Employee

11. Status: Fulltime Part-time Temporary Non-Employee Student Visitor

12 Length of Employment: ____ years 13 Time in occupation when incident occurred: ____ years

14. Describe Exactly what happened, Include timeline of event and OBJECT or SUBSTANCE that caused harm:
 An example would be: slipped on wet floor, exposure to cleaning chemicals, cut with carpet knife. (For informational purposes, please submit detailed information on the appropriate [Incident Description Statement Form\(s\)](#).)

15 Location of Incident include building and room number, state if outdoors :
 (An example would be: Injury occurred at Engineering Sciences Building , Room G38)

16. Describe the INJURY or ILLNESS and Specific BODY PART(S) affected (An example would be: cut on palm of left hand or sprained lower back)

SECTION TWO

17. Was the victim wearing Personal Protective Equipment? (please specify) _____

18. Was the employee seen by a physician? Yes No 19. Name of Physician _____

20. Location of Treatment _____

21. Was employee in Emergency room? Yes No 22. Was employee hospitalized overnight as a patient? Yes No

23. Type of Treatment received: (check type)

Set Fracture/broken bone Treat Infection Stitches/Sutures Tetanus Shot Surgery

Prescription Physical Therapy (more than once) Remove foreign Object from eye

Hearing Loss Other (explain) _____

SECTION THREE

24. Total lost work days after the day of incident _____ 25. Total days of restricted activity _____

26. If employee has not returned to work check here [Please complete Employee Return-To-Work Notice](#)

27. Was Worker Compensation Filed? Yes No

Employee's Signature _____ Date _____

Supervisor's Name _____ Signature _____ Date _____

Reviewer's Signature _____ Date _____

(EHS use only) Healthcare needlestick injuries only: Sharps Injury: _____

RETURN COMPLETED FORM TO: West Virginia University-Environmental Health and Safety
 Attn: Injury/Illness Prevention Program
 PO Box 6551
 Morgantown, WV 26506-6551

On-The-Job Injury Witness Statement

Name of Injured Employee: _____

Date of Injury: _____

What Happened: _____

Print Name: _____

Signature: _____

Fax to: 304.293.2644

**West Virginia University
Workers Compensation
Temporary Total Disability Benefits or Sick Leave Benefits
Option Election Form**

Employee Name: _____

Social Security Number: XXX-XX-XXXX

Date of Injury: _____

No Loss Time/Less Than 3 days: _____

Employee: Please submit this completed form to WVU Human Resources office. If you are absent from work due to an approved work-related injury, you must choose to receive either Employer paid sick leave or Workers Compensation Temporary Total Disability (TTD) benefits. Please read the following and clearly indicate your option choice.

Option 1 – Repayment of Sick Leave Used

If you elect to receive TTD benefits, you may use sick leave until you receive your initial TTD benefit check. However, this leave will be restored when you reimburse your employer the net value of the paid sick leave use, and upon return from current leave. Leave reinstated cannot be used until after the return to work. I elect to receive Workers' Compensation TTD benefits; however, I understand that I may use sick leave (or annual leave after sick leave is exhausted) *only until* I receive my initial TTD benefits check. I understand that while receiving TTD benefits, I will be in a leave of absence without pay status. During this leave of absence without pay, I understand that I will continue to accrue years of service credit and annual leave only, which can continue through the one year medical leave of absence, and which will allow for the calculation of longevity pay only through the one year medical leave of absence. I understand that while in the leave of absence without pay status, I will not be eligible to receive accrued sick leave, nor will I be paid for holidays during this leave.

Option 2 – Use Sick Leave – No Repayment

I elect to receive sick leave benefits instead of Workers' Compensation TTD benefits for the period that I am absent from work due to an approved work-related injury. While I am receiving paid leave benefits (e.g. sick leave and annual leave after sick leave is exhausted), I understand that I will continue to accrue annual leave, sick leave, and be paid for holidays that occur during this period. I also understand that while in this leave status, I will continue to accrue years of services, which will allow for the calculation for longevity pay. This will apply to the period within the one year medical leave of absence only. If I should exhaust my sick leave and annual leave (if requested), I understand that I am eligible to receive TTD benefits during the remaining period of absence from work due to a 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, and will receive service credit allowance for the calculation of longevity pay and accrued annual leave, but only while I am within the one-year medical leave of absence time period. While I am absent from work, and in a leave of absence without pay status, I will not accrue sick leave and I will not be paid for holidays.

Employee Statement: I understand that I must choose either Workers' Compensation TTD benefits or paid sick leave, and that I am not legally entitled to both for the same period of absence. I understand that if I elect to receive TTD benefits and choose to receive paid sick leave until I receive my initial TTD benefits check, I must reimburse the value of the paid leave to my employer, who will then restore that leave. If I fail to reimburse my employer the value of the paid leave used, I understand such amount will be deducted from future wage payments. I understand that the value of the paid leave period is not provided at the time I sign this form, and that I have the right to investigate the value on my own, if I choose to do so.

Employee's
Signature: _____

Date Submitted: _____

To be completed by the Employer:

Signature: _____

Date Received: _____

The Terms of this Option Election form are binding, and cannot be changed at any time in the future. This option election will apply only to the period within the one-year medical leave of absence. If no return to pre-injury position is possible within this timeframe, the option will no longer apply after separation from employee's position.

Please note: If this form is not received within 5 days of your receipt, we will abide by the option chose on the BI-1/2.

I choose to freeze my annual leave as of . I understand it is my responsibility to notify my EBO of this decision.
(date)

West Virginia University Medical Verification Form

Employee to Complete

Employee's Name: _____ Date of Birth: _____

Home Address: _____ Home Phone Number: _____

Leave due to Workers' Compensation? _____ Department: _____

Supervisor: _____ EBO Contact _____

I hereby authorize West Virginia University to obtain any medical documentation necessary to process this request. I understand that this form needs to be completed in full and additional medical information may be required. WVU will request additional information if needed. I am aware that WVU seeks medical information in order to assess employability options including accommodation or restriction from work. Sick or annual leave charged will be determined based upon information provided. Leave determinations include Family Medical Leave Act, Parental Leave Act, ADA monitoring, use of sick leave and Catastrophic leave.

Employee's Signature

Date

Physician to Complete

Diagnosis or ICD-9 Code

Prognosis

Maternity Date and Method of Delivery

Physician Comments /Treatment Plan:

This is to certify that the above mentioned employee has been under my professional care. I support his/her absence from work starting _____ through and including _____.

May return to work on _____ with no restrictions. Will be re-evaluated on _____.

IF THE EMPLOYEE HAS ANY WORK RELATED RESTRICTIONS, PLEASE SEE PAGE 2

Physician's signature

Date

Name of physician (please print)

Physician's Phone

**WVU Division of Human Resources
Medical Management Unit
PO Box 6640
Morgantown, WV 26506-6640
Phone: (304) 293-5700 Ext 8 Fax: (304) 293-2644**

THIS PAGE ONLY NEEDS TO BE COMPLETED IF THERE ARE WORK RELATED RESTRICTIONS

Patient's Name: _____ Is released to return to work on _____ with the following **restrictions:**

Hours per day Normal Schedule If limited please specify _____

Days per week Normal Schedule If limited please specify _____

Lifting Restricted to no greater than: 50 lbs. 20 lbs. 10 lbs. 5lbs. other _____

Restrictions during a work shift

Bending/Stooping 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Pulling/Pushing 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Overhead Reaching 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Sitting 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

Standing 0 hours 1-3 hours 3-5 hours 5-8+ hours No restriction

If other limitations please specify: _____

These restrictions are to be in effect starting _____ through and including _____.

These limitations are: **Permanent** **Temporary**

May resume regular duties on _____ **OR** Will be re-evaluated on _____.

I hereby certify that the above information is true and correct and that it is my responsibility to give objective medical information. West Virginia University will take the suggestions that medical providers make into consideration, but it is the employer's decision as to whether the accommodation can be met in a reasonable fashion.

Physician's signature Date

It is the employee's responsibility to submit these restrictions to Medical Management prior to returning to work. Medical Management will notify the employee if their position can be modified to meet these restrictions, or if they will need to remain off work on medical leave.

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