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 that an injury has occurred **within 24 hours**.
   b. Complete supervisor's injury/illness report and return **within 24 hours**. Original should be mailed to EH&S and a copy should be faxed or emailed to Medical Management.
   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 B-1 & 2 form at treating physician's office (BrickStreet Mutual Insurance is our WC Carrier).

3. **Release:**
   a. 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 should be emailed, faxed or delivered to Medical Management.
   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:**
   a. 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 can 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. A witness to an on-the-job injury who wishes to submit a statement should complete the Witness Statement Form. This form should be sent along with the injury report.

**Contact Information:**
Medical Management
One Waterfront Place, PO Box 6640
Phone: (304) 293.HURT
Fax: (304) 293.2644
Email: medicalmanagement@mail.wvu.edu
Call 9-911 for: loss of consciousness, stroke, seizures, heart attack, electric shock, allergic reaction or bleeding.

For EHS use only OSHA Recordable __ Yes __ No

Privacy Case Needlestick Body Fluids Animal Bite Asbestos Chemical Spill Pharmaceutical/Biohazard
WVU Occupational Medicine Health Care Evaluation Recommended Describe on page 2 reason for Evaluation
Serious Injury __ (Notify within 24 hrs. for hospitalization)
Fatality __ (Notify within 8 hrs.)
Near Miss __ Exposure __

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

3. Gender: ___ Female ___ Male 4. Date of Birth / / or Age ___ 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 ___ Research Corp ___ Health Sciences

11. Status: ___ Full-time ___ Part-time ___ Temporary ___

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 attached "Incident Description Statement Form").

15. Location of Incident include building and room number, state if outdoors: i.e. Engineering Sciences Bldg., 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)

Exposure -EHS must receive a completed copy of the "Employee Injury/Incident Report" within 24 hours of the exposure.

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

18. Was the employee seen by a physician? ___ 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 ___ Does this issue need reviewed for ADA Concerns ___ Other-explain on back of form

Needlestick or Body Fluids — please report to local emergency room immediately (Ruby hospital after 4:30 p.m.

and call Occupational Medicine at 304.293.3693 for follow up) See link to CDC guidelines for Shanks injury treatment at http://www.cdc.gov/niosh/105006/whattodo.html

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. Does employee wish to file a Worker Compensation Claim? ___ Yes ___ No

28. Does this incident require EHS to investigate for alternative information and causal factors? ___ Yes ___ No

Employee’s Signature __________________ Print __________________ Ph. Number ___________ Date __________

Supervisor’s Signature __________________ Print __________________ Ph. Number ___________ Date __________

(Or reviewer’s)

Email: Carol.Wells@mail.wvu.edu P.O. Box 6551 For Health Science email: Natalie.Caravans@mail.wvu.edu
INCIDENT DESCRIPTION STATEMENT FORM

Supervisor, Injured Employee, and Witness complete a separate Statement Form

Please check appropriate box

☐ Supervisor    ☐ Employee    ☐ Observer

Name of Injured Employee: ____________________________________________

Date of Injury: ____________________________________________________

Description of Incident: Describe in detail exactly what happened, Include: task(s) and procedure(s) being performed, timeline of events, and OBJECT and/or SUBSTANCE that may have been involved.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Name (Printed): ____________________________________________________

Signature: ____________________________ Date: ________________________

Supervisors complete form and immediately fax to EHS (304) 293-7257 or mail Environmental Health and Safety Injury/Ilness Prevention Program, PO Box 6551, Morgantown, WV 26506.

Email: All campuses: Carol.Wells@mail.wvu.edu  P.O. Box 6551

For Health Sciences include email: Natalie.Carrovers@mail.wvu.edu
WVU EMPLOYEE INJURY/INCIDENT REPORT-Report Incident within 24 hours (see emails/phone # below)

AND Amanda.Biddle@mail.wvu.edu Medical Management

WVU EHS Employee Incident Form Rev 01.31.2017
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 benefits check. However, this leave will be restored when you reimburse your employer the net value of the paid sick leave used 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 period, 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 service, 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 the benefits, I will be in a leave of absence without pay status, and will receive service credit allowance for the calculation of longevity, but not accrued annual leave, but only while I am within the one-year medical leave of absence time period. While I am away 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, I must 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 shall be deducted from future wage payments. I understand that the value of the paid leave period is not provided at the time I submit 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:________________________

Work Related-Injury? □ yes □ no Department:________________________

Supervisor:________________________ Employee#:________________________

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)

(Comorbidities) (Maternity Date and Method of Delivery)

Treatment Plan/Type of Surgery:________________________

Employee needs to be off work consecutively from________________________ through and including________________________

And/Or

Employee needs to be off work intermittently from________________________ through and including________________________

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

Physician Comments:________________________

________________________________________________________________________

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

Physician's signature:________________________ Date:________________________

Physician's Phone:________________________

Name of physician (please print):________________________

Physician's Fax:________________________

WVU Division of Human Resources
Medical Management Unit
PO Box 6640
Morgantown, WV 26506-6640
Phone: (304) 293-5700 Ext 8 Fax: (304) 293-2844

Revised 3/2012
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 less than: □ 50 lbs  □ 20 lbs. □ 10 lbs. □ 5 lbs. □ other______ □ No restriction

**Restrictions during a work shift**

Bending/Stooping  □ May not perform  □ 1-3 hours □ 3-5 hours □ 5-8+ hours □ No restriction

Pulling/Pushing  □ May not perform  □ 1-3 hours □ 3-5 hours □ 5-8+ hours □ No restriction

Overhead Reaching  □ May not perform  □ 1-3 hours □ 3-5 hours □ 5-8+ hours □ No restriction

Sitting  □ May not perform  □ 1-3 hours □ 3-5 hours □ 5-8+ hours □ No restriction

Standing  □ May not perform  □ 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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