SELF-INSURED WORKERS' COMPENSATION PACKET

Accident Reporting Procedure

This form can be obtained online at www.findlay.edu

INSTRUCTIONS:

- Review document.
- Sign and date form and return to the Office of Human Resources.

In the event of an accident, injury or incident, no matter how minor, the *Safety Incident Report* must be completed no later than the end of the shift during which the accident occurred. If the injured worker seeks treatment the following must be completed:

1. Complete the entire *Self-Insured Workers' Compensation Packet* (SIWC Packet) immediately or as soon as possible after medical treatment.
2. Telephone the Office of Human Resources 419-434-6964 (ext. 6964) immediately. If after hours, notify security by telephone 419-434-4799 (ext. 4799). You must report any injuries sustained at work in order to establish valid claims under state workers' compensation law. In addition, the University must comply with federal and state injury recordkeeping requirements.
3. After a medical appointment, you are required to report directly back to your supervisor. If your shift has ended or the physician sends you home, you must contact your supervisor prior to your next scheduled shift.
4. If a medical visit is not required at the time of injury, but is later necessary, you must immediately notify your supervisor. If you are unable to contact your supervisor, notify the Office of Human Resources 419-434-6964 (ext. 6964).

Safety Concern Reporting Procedure

Each employee is individually responsible for accident prevention. It benefits all employees and the University if you report any situation or condition which you believe may present a safety hazard. The University encourages you to report your concerns to either your immediate supervisor or the Office of Human Resources. The matter will be investigated immediately.

Light Duty Work Program and Compensation

The University of Findlay has an extensive light duty work program. The University's goal is to have the employee return to work quickly and safely – either in the same position or a temporary work assignment until the employee is released to resume their same position or possible work site modification.

The University, as a self-insured employer, may pay a lost-time claim as temporary total (TT) compensation benefit through the certified Workers' Compensation claim. Specific Workers' Compensation forms must be submitted by the injured worker and physician of record. A lost-time claim is defined as: a claim in which an injured worker has missed 8 or more calendar days from work due to an injury or occupational disease. (The days do not have to be consecutive). The TT is paid at a percentage of the employees' wage as mandated by the Bureau of Workers' Compensation (full weekly-wage [FWW] and average weekly-wage [AWW] as outlined in the Procedural Guide to Self-Insured Claims Administration). Benefit time (Sick Leave or Vacation) must be utilized if you are unable to provide a doctor's slip documenting your time off.

Injured Person Signature _____ Date _____

University of Findlay

Checklist for Handling Work-Related Injury

INSTRUCTIONS: *This form can be obtained online at www.findlay.edu*

- Print or type.
- Sign and date form and return to the Office of Human Resources

Injured worker name (First, M.I., Last)			Date and time of Injury
Address	City	State	9-digit ZIP code
Employer name	Department		

When an accident, injury or incident occurs, follow the steps listed below:

1. A supervisor or a designated representative should attend to the injured worker and may accompany the injured worker to the locations listed below. Provide the injured worker with a *Self-Insured Workers' Compensation Packet*.

   a. Cosiano Health Center on-campus facility, if the injury is minor.
   b. Well at Work, 3949 North Main St., Findlay, OH 45840, 419-425-5121, if the injured worker's location is the Main Campus or The All Hazards Training Center.
   c. Emergency Room of Blanchard Valley Regional Health Center, 145 West Wallace St., Findlay, OH 45840, 419-423-5207, if the injured worker's location is the East or South Campus.
   d. In the case of an emergency or after-hours event, employees should dial 911, if appropriate, and go to the nearest hospital emergency room or urgent care center for treatment.

   The employee should identify themselves as an employee of the University when seeking outside medical attention and inform the provider the injury is work related. The employee or supervisor should be sure to take a SIWC packet to the location. If outside medical attention is required after sustaining a work-related injury, employees may be subject to alcohol and/or drug testing pursuant to the University's Drug and Alcohol Policy.

   HANCO (ambulance service) will provide transportation to Well-at-Work or the Emergency Room of Blanchard Valley Regional Health Center. The injured worker has the right to refuse HANCO transportation.

   It is highly recommended that the employee utilizes a Bureau of Workers' Compensation Certified Physician, since there are specialized documentation and forms that are required for the claim and must be completed in a timely manner. Make sure the provider knows the injury is work related.
   Date completed: _____

2. Report the injury to the Office of Human Resources within 24 hours. Failure to report an injury in a timely manner may affect the processing of benefit and compensation requests and may also lead to disciplinary action up to and including termination of employment. Date completed: _____

3. Have the provider and injured worker complete the *First Report of Injury* (FROI) if possible before leaving the place of treatment and return it to the Office of Human Resources within 24 hours along with a completed Safety Incident Report. Provide the enclosed Provider Notice to place of treatment.
   Date completed: _____

4. Notify the Office of Human Resources with any details related to the injury, e.g., return to work date, any restrictions or reasonable accommodations, etc. Send back up paperwork given to injured worker by the provider as well as completing the Safety Incident Report and FROI.
   Information and date sent to HR: _____

Have the injured worker contact the Office of Human Resources at 419-434-6964 as soon as possible.

_____ _____

Injured Person Signature Date

Bureau of Workers' Compensation

First Report of Injury, Occupational Disease, or Death (FROI)

Submit the form to BWC in one of the following ways. **Online:** bwc.ohio.gov, **Fax:** 1-866-336-8352, **Mail:** BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215
Note: If you work for a self-insuring employer, submit this form to your employer's workers' comp manager.

Injured worker information

First name, middle initial, last name	Date of injury/disease	Social Security number	Date of birth	

Mailing address; add apartment number or P.O. Box, if applicable	City	State	ZIP code

Sex ☐ Male ☐ Female	Email address	Home phone number	Cell phone number

Employer name	Employer address	City	State	ZIP code

Was the injured worker hired through a temp agency? ☐ Yes ☐ No If yes, name of temp agency	Mark the days of the week you usually work ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat	Regular work hours (include a.m. p.m.) From To

Date hired	Job title	State where hired	State where supervised	Wage rate; $ per hour	Number of hours scheduled to work the week of this injury

Work number for call-offs (Number injured worker calls to reach supervisor)	Part(s) of body affected (For example: Left knee, right index finger)

Accident description (Describe the sequence of events that directly caused the injury or death.)	**Will the incident cause the injured worker to miss 8 or more days from work?** ☐ Yes ☐ No

Injured worker start time _____ ☐ am ☐ pm	Time of injury _____ ☐ am ☐ pm	Date employer notified	Was any part of a workday missed due to the injury? ☐ Yes ☐ No	Date last worked	If the injured worker has returned to work, provide the date.

Was the place of the accident or exposure on employer's premises? ☐ Yes ☐ No If no, give accident location, street address, city, state, and ZIP code.	Was injured worker hospitalized overnight? ☐ Yes ☐ No

Initial treatment date	Health-care office/Facility name	Treating physician/Provider name	Telephone number	Fax number

Health-care office/Facility street address	City	State	ZIP code

If the injury resulted in death, answer the following.

Date of death Decedent's marital status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Decedent's number of dependents

To be completed by the injured worker

By signing this form, I:

- **Elect to only receive compensation, benefits, or both provided for in this claim under Ohio's workers' compensation laws.**
- **Understand, waive, and release my right to receive compensation and benefits under the workers' compensation laws of another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**
- **Confirm I have not received compensation and benefits under the workers' compensation laws of another state for this claim, and I will notify BWC immediately upon receiving any compensation or benefits from any source for this claim.**
- **Will not file and have not filed a claim in another state for the injury, occupational disease, or death resulting from an injury or occupational disease for which I am filing this claim.**

Furthermore, I understand that:

- Upon request, my treating providers may submit to BWC, my employer, my employer's managed care organization or qualified health plan, or their authorized representatives medical, psychological, psychiatric, or vocational documentation relating causally or historically to physical or mental injuries relevant to this claim and necessary for me to obtain medical services, benefits, or compensation.
- Proper administration of this claim may require BWC to review and share with the employers of record, their authorized representatives, or my authorized representative any information or record maintained in this claim, or in my previous or future claims.
- Information or records maintained in my previous or future claims may affect decisions made in this claim.
- Any person who obtains compensation or benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements, or accepting compensation or benefits to which he or she is not entitled, is subject to felony criminal prosecution for fraud (Ohio Revised Code 2913.48).

I certify that I have read, understand, and agree to the above statements and the information contained on this form is true and accurate to the best of my knowledge.

Injured worker signature	Date

To be completed by the treating provider

Diagnosis(es)-narrative description including as appropriate, the location and body part, and ICD code(s). **Important:** If there is an injury, list the condition or disease, not the symptoms or exposure. For example, "sprain right knee" not "pain right knee", "toxic effect of ammonia" not "exposure to ammonia", "contusion to the head" not "headache".

Initial treatment date	Are the medical conditions you have listed above causally related to the reported work-related accident or occupational disease? ☐ Yes ☐ No Are you the physician of record? ☐ Yes ☐ No

Treating physician/Provider's name (Print)	Treating physician/Provider's signature	BWC provider number	Date

To be completed by the employer

Employer name	Employer county	Phone number	Fax number	Email address

Employer policy number	Federal ID number	Injured worker is (Check box, if applicable.) ☐ Owner/Sole proprietor ☐ Partner ☐ Individual incorporated as a corporation

For all employers: ☐ Certification – I certify the facts in this application are correct and valid. ☐ Rejection – I reject the validity of this claim for the reason(s) listed below.
For self-insuring employers only: ☐ Medical only ☐ Lost time
Clarification – I clarify and allow the claim for the condition(s) below.

Employer signature and title	Date

To be completed by the submitter if the form is completed by someone other than the injured worker, treating physician, or employer

Signature of person completing this form	Date

University of Findlay

Accident File # (completed by HR)

Injured Person's Report of Accident

This form can be obtained online at www.findlay.edu

INSTRUCTIONS:

- Print or type.
- Sign and date form and return to the Office of Human Resources

Employer	Employer Address
Location - if different from mailing address	Date of Report

Injured Worker Name (first, M.I., last)	Age	Sex	ID #	Social Security #
Address	City	State	9-digit ZIP code	
Phone #	Occupation	Department		

Date of Accident/Illness	Time (designate a.m. or p.m.)
Place of treatment for injury/illness	Exact location of accident
Job or activity at time of accident	Were you working at the time of accident?
Supervisor at time of accident	Names of witnesses to accident
Name of person to whom injury was reported	Name and address of physician, if seen
Name and address of hospital, if hospitalized	

Report prepared by: _____ Position: _____

Description of Accident - In the space below, describe how your injury was sustained and state in detail what you were doing at the time and what you did immediately thereafter. Include details such as how the accident occurred, the specific body parts affected, what injured you: _____

Describe any unsafe acts: _____

Describe any unsafe conditions: _____

_____ _____

Injured Person Signature Date

University of Findlay

PROVIDER NOTICE

THE UNIVERSITY OF FINDLAY IS SELF-INSURED FOR WORKERS' COMPENSATION EFFECTIVE: JULY 1, 2000.

PLEASE SEND ALL CORRESPONDENCE, BILLING, AND INFORMATION TO:

OFFICE OF HUMAN RESOURCES
THE UNIVERSITY OF FINDLAY
1000 NORTH MAIN ST.
FINDLAY, OH 45840
FAX 419-434-5976

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 419-434-6964.

THANK YOU.

The University of Findlay

For questions regarding your work injury, please contact V+A Risk Services, our Third Party Administrator (TPA).

V+A RISK SERVICES

Monica Cook

Sr. Account Manager

Phone: 800-493-9662 ext.121

Fax: 419-867-1049

mcook@variskservices.com

OPTUM

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

V and A Risk Services	The University of Findlay
CARRIER/TPA	EMPLOYER
INJURED WORKER NAME	
Please provide directly to Pharmacist	
SOCIAL SECURITY NUMBER	DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	VNARFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

OPTUM®

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...
EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

V and A Risk Services	The University of Findlay
PORTADORA	EMPLEADOR
NOMBRE DEL TRABAJADOR LESIONADO	
Please provide directly to Pharmacist	
NUMERO DE SEGURO SOCIAL	FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	VNAREF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG