What to Do When an Employee is Injured on the Job

The first thing to do is to provide first aid or medical attention. Any on-the-job injury, even a small cut or minor injury, should be treated appropriately.

Injuries Needing First Aid Only

First aid cases are injuries that do not require a treatment by a physician and are minor in nature, such as minor cuts, scrapes, bruises, and splinters.

1. **First aid** should be administered by a qualified person.
2. Complete a **FROI (First Report of Injury or Illness)** and send to Stacey Sasko at the Whitley County Board of Education.
   Email: stacey.sasko@whitley.kyschools.us
   Fax: 606-549-7006
3. Determine the cause of the accident, **Obtain names** of all witnesses.
4. All **corrective measures** should be applied to prevent future recurrences of the accident.

NOTE: If you have any questions or doubts relative to the seriousness of the injury, always treat as if one is requiring physician's treatment.

Injuries Requiring Physician Treatment

1. Secure the appropriate **medical attention** by taking the injured employee to a physician or to the nearest emergency facility (if warranted).
2. Complete a **FROI (First Report of Injury or Illness)** and send to Stacey Sasko at the Whitley County Board of Education.
   Email: stacey.sasko@whitley.kyschools.us
   Fax: 606-549-7006
3. Determine the cause of the accident, **Obtain names** of all witnesses.
4. All **corrective measures** should be applied to prevent future recurrences of the accident.
5. It is important to **follow up** on the injured employee's progress by visiting and calling the employee. Showing your concern for the employee's welfare and progress will often help the employee's recovery and return to the job.
6. If a serious injury occurs and equipment is involved, **do not move the equipment** if it can be left at the scene of the accident. In all cases, be sure the equipment is secured in a safe place and cannot be tampered with. Immediately contact the ClearPath Claims Department at 1-800-367-5372 for further instructions.

CLEARPATH mutual

FROI

Workers' Compensation First Report of Injury of Illness

1. **Who fills out the form?**

   The employer

2. **When should this form be filled out?**

   If medical treatment (even first aid) is provided for any employee, or if time is lost from work, you must fill out this form. It should be completed within 24 hours of the injury. Kentucky statute requires forms to be sent within three (3) days of knowledge of a loss. Violations of this can result in fines.

3. **What should I do in case of death?**

   Call ClearPath Claims Center immediately.

4. **What is knowledge of a loss?**

   The first date the employer has knowledge of an accident, including supervisors, payroll personnel, fellow employees, etc.

5. **How do I file the First Report of Injury or Illness (IA-1)?**

   Send completed report (iA-1) to Stacey Sasko at the Whitley County

   Board of Education:

   - Fax: 606-549-7006
   - Email: stacey.sasko@whitley.kyschools.us

Injuries That Require Immediate Contact with the ClearPath Claims Center

Call 1-800-367-5372

Head Trauma	Spinal Cord Injury
Stroke	Amputation
Heart Attack	Hospitalization over 24 Hours
Severe Burns	Death

ClearPath Mutual
Workers' Compensation
PriorityRx Prescription Payment Authorization Form

Please keep this Authorization Form on file with script for auditing purposes.

Pharmacist:

This is a temporary workers' comp Rx payment authorization form. Please submit the prescription using the processing information listed below.

Please contact the M. Joseph Medical Help Desk at 844-DME-AND-Rx (844-363-2637) if you have any questions.

To transmit a prescription claim, please use the following information:

Processing information

Processor: EHO (Employer Health Options)
Bin #'s: 004527 (most pharmacies use this number)
Envoy/WebMD = 003241
CVS Condor Code = 15721
Eckerd's/Rite Aid Condor Code = 2185

(These specific pharmacy chains require special numbers to transmit prescriptions. All major chains and most independent pharmacies accept this plan.)

Version: D.O

Patient Information

Last Name: _____

First Name: _____

Group#: 81045 Sex: Male ☐ Female ☐

ID#/ SS#: _____

D.O.B.: ___/___/_____

Prior Authorization #: _____**(retain this # for future use)**
YYMMDD format ex: July 20, 2014 would be 140720

Date Sent: _____

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Whitley County Board of Education
300 Main St
Williamsburg, KY 40769

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

INDUSTRY CODE | EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

ClearPath Mutual Insurance Co.
9960 Corporate Campus Drive, Suite 1400
Louisville, KY 40223

POLICY PERIOD
TO

CHECK IF APPROPRIATE
SELF INSURANCE ☐

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ PM ( ) CANNOT BE DETERMINED | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSP
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HOURS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.