



A BETTER HANDLE
ON WORKERS' COMP

Realfine Painting LLC

1 Barlow RD SW

Lakewood WA 98499

253-651-4908

Employee Incident Procedure Packet

1. Report incident to your supervisor immediately.
2. Fill out the attached Employee Incident Report.
3. If you are **NOT** seeking treatment from a medical provider give the completed Employee Incident Report to the manager on duty.
4. If you **ARE** going to seek treatment from a medical provider you **MUST** give the completed Employee Incident Report to the manager on duty **AND** take the attached Return to Work Form to the doctor's office, **AND** inform the medical provider that your employer is **insured through the Department of Labor and Industries (L&I)**, has a "no time loss" philosophy and can provide transitional duty work available for any restriction.
 - a. We recommend you see (although you can see a provider of your choice):

<Insert name of nearest medical provider>

<address>

<address>

<phone umber>

If it is after hours and immediate medical attention is necessary, please see the nearest available medical provider.

5. You must return to work immediately after your doctor's appointment with the completed Return to Work Form and deliver it to your supervisor.
6. If restricted from work, your supervisor will present you with a job offer letter and a copy of the completed Return to Work Form signed by the medical provider.
7. You must check in with the supervisor after each doctor's appointment.
8. You must schedule all treatment outside of your scheduled work periods.

I have read and understand this incident reporting procedure listed above, **AND** I agree to follow the terms and physical restrictions of my release both at work and outside of work to help facilitate my recovery.

Employee Signature: _____ Date: _____

EMPLOYEE INCIDENT REPORT

Company Name& Job Location: _____

PART I - COMPLETED BY SUPERVISOR

The employer must report any incident to L&I that results in a fatality, in-patient hospitalization, loss of an eye, or an amputation within eight (8) hours by calling 800.4BE.SAFE.

Employee:	Job Title:	Time Shift Began: _____ AM / PM (circle)
Date of Incident:	Time of Incident: _____ AM / PM (circle)	Reported to Employer: ____/____/____
Employee's Home or Mailing Address:	Home Phone: () _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of Hire: ____/____/____	Last Full Day Worked: ____/____/____
	Date of Birth: ____/____/____	Shift (circle): _____ Day Evening Night

Seen by:	<input type="checkbox"/> Emergency Room <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other	1) Were prescription drugs prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Treating Caregiver's Name, Address & Phone: _____	2) Will employee lose time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No
		3) Was employee placed on modified duty? <input type="checkbox"/> Yes <input type="checkbox"/> No
		4) Was worker hospitalized overnight? <input type="checkbox"/> Yes <input type="checkbox"/> No
		5) Was the incident fatal? <input type="checkbox"/> Yes <input type="checkbox"/> No
		6) If fatal, date of death _____/_____/____

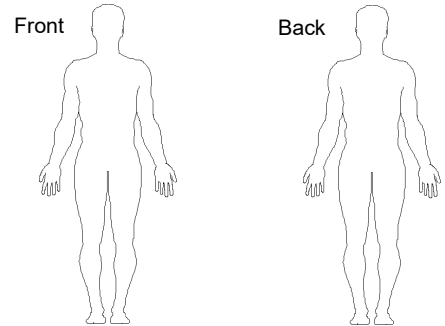
Describe in detail what happened to injure the employee (be specific, tools, materials, equipment, etc.):

What specific corrective actions have/are being made to prevent future incidents such as the one described above:

Part of Body (Circle side if applicable and check all parts that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Eyes (L or R) | <input type="checkbox"/> Ear |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Mouth | <input type="checkbox"/> Face |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder (L or R) | <input type="checkbox"/> Arm (L or R) |
| <input type="checkbox"/> Elbow (L or R) | <input type="checkbox"/> Wrist (L or R) | <input type="checkbox"/> Hand (L or R) |
| <input type="checkbox"/> Finger/Thumb | <input type="checkbox"/> Back | <input type="checkbox"/> Chest |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Groin | <input type="checkbox"/> Leg (L or R) |
| <input type="checkbox"/> Knee (L or R) | <input type="checkbox"/> Ankle (L or R) | <input type="checkbox"/> Foot (L or R) |
| <input type="checkbox"/> Toes | | |

MARK INJURED AREA(S) BELOW



- 1) Rate of Pay _____ per mo/wk/hr 2) Days Worked per Week _____ 3) Hours per Week _____
 4) Continue Health Benefits? (circle) Y or N 5) Monthly benefits (med/vision) paid \$_____ per mo/wk/hr

PAYROLL Fill out this section if employee misses more than one day of work.

PART II - COMPLETED BY EMPLOYEE

Employee statement of how incident occurred:

By signing below you are indicating that **1)** this incident occurred while at work, **2)** you understand light duty work could be available for you to return to work immediately, and **3)** you authorize your **medical provider(s) or therapist(s) to release any medical records** related to any similar or related conditions that pre-exist and/or adversely affect recovery from any injury related to this incident to my employer's workers' compensation representative.

Employee's Signature _____ Date _____

Form Completed By: _____ Phone: _____ Date: _____ Title: _____

OSHA Log case number _____ (transfer the case number from the OSHA 300 log after recording the case)

INCIDENT ANALYSIS GUIDELINES

The purpose of an incident analysis is to find the cause of an incident and prevent further occurrences, not to fix blame. An unbiased approach is necessary to obtain objective findings.

- If possible, interview injured workers at the scene of the incident and “walk through” a re-enactment. Be careful not to repeat the act that caused the injury.
- Privacy is important during interviews. Interview witnesses one at a time. Talk with anyone who has knowledge of the incident, even if they did not actually witness the mishap.
- Record names, addresses, and statements of witnesses. Consider taking signed, dated statements if facts are unclear or an element of controversy exists.
- In major injuries, use sketches, diagrams and photos to document details graphically. Take measurements when appropriate.
- Identify the circumstances preceding and surrounding the injury--what were underlying and contributing causes, as well as immediate causes?
- What physical hazards existed at the time of the incident, such as unprotected openings, poor housekeeping, slippery surfaces, protruding nails, etc.?
- Were defective tools, equipment or materials provided to or used by the employee(s)?
- Was personal protective equipment (PPE) provided? Was PPE defective, not used, or used improperly? Was PPE needed?
- Did unsafe work practices contribute to the injury, including improper lifting, handling of materials or equipment failure?
- What safety rules or safety training might have prevented the incident?
- If a third party or defective product contributed to the accident, save any evidence. It could be critical to the recovery of claim costs.

Incident Analysis Discussions:

Did you discuss with the injured employee’s supervisor the details of the incident and obtain names of witnesses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you get statements from all witnesses with information (directly or indirectly) concerning incident/injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you analyze the safety measures that were in force at the time of injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you analyze whether or not equipment or mechanism failure, or another person/party (contractor, etc.) was a factor in the incident/injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you reviewed and evaluated all documentation to identify the cause of the incident (including the circumstances preceding the injury)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you taken steps to implement a solution so this type of incident does not occur again, such as training or engineering controls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you report this incident to Employer Resources Northwest (ERNWest)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was employee admitted to hospital overnight? Was there a fatality, loss of an eye or amputation? If so, you MUST report to incident to LNI 800-4BE-SAFE <u>AND</u> prepare for possible LNI Inspection.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you enter this incident/injury on the OSHA 300 Log (if applicable)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Worker's Name _____

Return To Work Form {FA2}

Claim Number _____

We are committed to returning our staff member back to work as soon as medically possible and we need your help! Please give this document back to our employee during your visit with them, they are required to return this to us within one (1) business day so we can try and assist in their rehabilitation by providing modified work. **YOU CAN BILL FOR FILLING OUT THIS FORM BY USING L&I CODE 1074M.**

We have identified multiple modified-duty options for our staff members, please check one. Unless otherwise specified here _____ (indicate # of hours per day & days per week), we are assuming this modified duty is approved for 40 hours per week. Below, we have outlined modified jobs we can provide, please check ANY JOB to which our employee is released and cross out any task our employee should not be performing.

Regular Work

Return to work with no restrictions

OR

Modified Duty – Select one of the following:

Crew Assistant: Up to 20 pounds

Essential Functions - Individuals employed in this capacity will be responsible for tasks that include but not limited to assists other crew members with obtaining necessary supplies and equipment to successfully complete an assigned project(s) where necessary supplies and equipment are maintained on the work-site. Individual may assist with holding or placing items with/for co-workers. Assists crew members with providing required tools or supplies as needed to expedite the project. Inventories supplies and reports quantities for determining amounts on-hand. Performs necessary housekeeping tasks to keep project area free of debris. Ensures walkways are clear of tripping hazards to ensure garbage, debris, hoses, cables, cords, etc. Ensures safety or warning signs are place correctly and remain in place. Assist with unloading or loading of vehicle with supplies and equipment. These tasks will be repeated throughout the work shift and may include at multiple work sites throughout the day until the work shift completed.

Standing: Frequent	Carrying: 0 - 20 lbs.	Grasping/Handling: Frequent (Forceful Occasionally)
Sitting: Rare	Lifting: 0 - 20 lbs.	Bending/Squatting: Occasional
Walking: Frequent	Push/Pull: 0 - 20 lbs.	Twisting/Climbing: Occasional

Supply/Equipment Runner: Up to 15 pounds

Essential Functions - Individuals employed in this capacity will be responsible for tasks that include but not limited to assists operations with obtaining necessary supplies and equipment necessary to successfully complete an assigned project(s) where necessary supplies are obtained, other project locations, or main business location. Verifies type and quality of supplies and materials are correct before departing supplier location and ensuring loaded supplies and materials are safely loaded and the supplies and materials and appropriately secured to the vehicle within physical capacities before leaving the supplier location. Upon arrival at work site removes tie down devices within physical capacities. As vehicle is unloaded, perform necessary work site housekeeping and pick up trash and other material and supplies to be disposed with their physical capacities. Once vehicle is off loaded, if necessary assists with loading of material and supplies that may need to be removed from a work site to be delivered to another. While loading is completed will inventory items to be loaded and annotate type and quantity of supplies and materials being transported. These tasks will be repeated throughout the work shift and may include multiple work sites throughout the day until the work shift completed.

Standing: Occasional	Carrying: 1 - 15 lbs.	Grasping/Handling: Frequent (Forceful Seldom)
Sitting: Occasional	Lifting: 1 - 15 lbs.	Bending/Squatting: Occasional
Walking: Occasional	Push/Pull: 1 - 15 lbs.	Twisting/Climbing: Rare

Please see next page →

Shop/Site Assistant: 0-10 pounds alternate sit/stand/walk at discretion

Essential Functions - Individuals employed in this capacity will be responsible for tasks in support of the shop staff performing duties which include but are not limited to receive, verify and count incoming orders; inventory raw materials and components; stock materials/supplies using material handling devices; dispense or receive tools and equipment; store/clean/stock tools and equipment after use and ensure scheduled vehicle are loaded with required tools, equipment, and supplies; schedule tool and equipment maintenance; paint or label tools and equipment (company i.d.); sort tooling and hardware; cleaning company vehicles; performing general housekeeping.

Standing:	Occasional	Carrying:	1 - 10 lbs.	Grasping/Handling:	Frequent (Forceful seldom)
Sitting:	Occasional	Lifting:	1 - 10 lbs.	Bending/Squatting:	Seldom
Walking:	Occasional	Push/Pull:	1 - 10 lbs.	Twisting/Climbing:	Rare

Administrative Assistant: 0-5 pounds alternate sit/stand/walk at discretion

Essential Functions - Individuals employed in this capacity will be responsible for tasks that include but not limited to working in support of the office staff performing clerical duties which include but are not limited to opening, sorting, and dispensing mail; copying or scanning documents; creating file folders and filing invoices; working on a computer to complete data entry or document preparation; maintains inventory of office supplies and other materials; completes company manual and log updates or corrections as assigned; and performs other related duties as assigned by the direct supervisor.

Standing:	Occasional	Carrying:	1 - 5 lbs.	Grasping/Handling:	Frequent (Not forceful)
Sitting:	Occasional	Lifting:	1 - 5 lbs.	Bending/Squatting:	Not Required
Walking:	Occasional	Push/Pull:	1 - 5 lbs.	Twisting/Climbing:	Not required

DEFINITIONS	
Rare:	0% - 10%
Occasional:	11% - 33%
Frequent:	34% - 66%
Constant:	67% - 100%

Medical Provider Signature **REQUIRED** _____ Date _____ Medical provider name and phone _____ () -

This form should be returned to the injured employee during their appointment to facilitate a quick return to work. If this is not possible, please fax it to 877-717-0590.

_____, 20__

RE: L&I Claim #: _____

Dear _____,

I am pleased to offer you employment with _____ that will accommodate your current physical capacities. The job is that of _____. This job is available on a reasonably continuous basis and additional modifications can be made based on objective medical findings and associated restrictions. The details of this offer are subject to all hiring and employment requirements and may include verification of employment eligibility and drug testing. A detailed description of the job which was approved by your attending medical provider on _____, 20__ has been attached for your review. The specifics of this offer include but are not limited to:

1) You will report for duty on _____, _____, 20__ at ___:___ am/pm (circle) at the following address:

2) Your shift will begin at ___:___ am/pm and last until ___:___ am/pm _____ through _____. You will be scheduled for _____ hours per week. This is based on your pattern of employment established prior to the date of your injury.

3) **You will report to _____ who will act as your direct supervisor**, and has been advised of your physical capacities.

4) Your wage will be \$____.____ per hour and you will receive benefits in accordance with our company policy.

5) If you have additional medical appointments, you must schedule them outside of work hours unless approved by a supervisor, or scheduled by L&I.

6) As necessary, training will be provided to help satisfactorily complete assigned duties not previously performed.

7) Should you experience any difficulties in the performance of your duties; you are to report them to _____ as soon as possible. You should not take it upon yourself to perform any task that is outside the physical limitations determined by your attending medical provider. Should you voluntarily work beyond your physical limitations as prescribed by your attending physician, actions will/may be taken in accordance to company policy.

8) This employment relationship is at-will which means both we as the employer and you as the employee are free to end this relationship at any time with or without cause.

Upon receipt of this letter please contact me, _____, at () _____ - _____ to accept or decline this job offer. If I am unavailable, please leave me a message for I am the only authorized individual that may accept your decision. This position is available immediately if you wish to return to work before the start date.

The Department of Labor and Industries has been notified of this job offer. Please check the appropriate box below and return this letter to me, _____, by hand, or post-marked before _____, _____, 20__ at ___:___ am/pm. If you do not show up for work on _____, _____, _____, 20__ at ___:___ am/pm your claim benefits may be affected.

_____ I ACCEPT THIS OFFER

_____ I DECLINE THIS OFFER (may affect L&I time loss benefits)

Employee's Signature

Date

Sincerely,

Encl.: Job Description Approved by Attending Medical Provider

Cc: L&I Claims Manager, ERNWest Claims Manager, Attending Medical Provider