Injury Management Kit

Previsor INSURANCE | MEM MISSOURI EMPLOYERS MUTUAL

6.23

Injury Management

INJURIES AT A GLANCE

Use this chart to help determine the level of care your injured worker requires. **If the injured worker is unresponsive, too ill to speak, or has one of the injuries listed in the emergency column, call 911 immediately.** If not, call our 24/7 NurseAid Work Injury Line at 1.800.442.0593 **before** seeking medical care.

EMERGENCY

- Acute spine/neck injury
- Amputation
- Broken/exposed bones
- Chemical exposure
- Chest pain
- Crush injuries
- Dizziness/weakness
- Electrocution
- Head injuries
- Severe bleeding
- Severe burns
- Severe seizure

911

TRIAGE

- Aches and pains
- Allergic reactions
- Ankle injury
- Back pain
- Bites
- Bumps and bruises
- Eye irritation/ redness
- Finger laceration
- Knee injury
- Lacerations
- Minor burns
- Minor cuts
- Neck pain
- Puncture
- Rashes
- Shoulder injury
- Soft-tissue injuries
- Sprains and strains
- Tetanus shot or booster
- Wrist injury

1.800.442.0593

Note: After arranging care for the injured worker, you must report the claim to MEM via phone (1.800.442.0593), online (mem-ins.com) or fax (1.800.442.0597).

Injury Management

QUICK GUIDE

I've just had an incident and someone is injured. What do I do?

Missouri Employers Mutual is here to help. Use this step-by-step guide to determine the best path for your injured worker before you seek medical care.

1 ASSESS THE INJURY

Does the injury involve **excessive blood loss**, a **head injury**, or a **serious bone fracture**?

YES

The employee is in need of emergency medical care.
Call 911 immediately.

NO

Call our **24/7 NurseAid Work Injury Line** for treatment recommendation from a registered nurse.

2 REPORT THE CLAIM

After you've arranged care for the injured worker, you must report the claim to MEM. Check out your options below to report them.

File an eClaim online.

Filing your claim online is a simple and easy way to report a claim at any time. Visit **mem-ins.com** and click the ***File a Claim** link.

Report the injury by phone.

Call us and report the injury by phone at **1.800.442.0593**, if the incident is catastrophic involving a **fatality**, **hospitalization longer than 3 days**, or **ICU admission**. For catastrophic claims reporting after hours, select option 2 in the claims menu.

Fax your claim form.

Visit our ***Virtual Claims Kit** to download your state specific First Report of Injury form. Fax it to MEM at **1.800.442.0597**.

Now that you have obtained care for the injured worker and reported the claim, it's time to conduct a preliminary incident investigation. What happened? Where did it happen? Whether there was an injury or not, investigating the cause of the incident can help you prevent the same incident from happening again and future injuries. It can also help you identify attempted fraud. Don't blame or accuse employees. While corrective action may be needed later, just try to gather information at this time.

3 INVESTIGATE THE INCIDENT

Secure the area.

Take photos of the scene of the incident. Mark it as off-limits if you can, to preserve any evidence.

Did any other employees witness the incident?

YES

Interview them.

Take written statements using the ***Incident Witness Statement** of what they saw or heard as soon as possible — while memories are still fresh.

NO

Check security footage.

If you have workplace security cameras, check them now.

Document everything.

What did you discover?

Do you suspect the incident was caused by an equipment failure, or an employee under the influence? Use the ***Incident Investigation Report** to make note of everything you find. Check out the Injury Management Checklist in this guide for a post-incident checklist.

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previsorinsurance.com | mem-ins.com

1.800.442.0593

Injury Management Checklist

Has an incident occurred in your workplace?
Use the following checklist in the event of a workplace injury.

1 WHAT TO DO WHEN AN INJURY OCCURS

☐ OBTAIN CARE FOR THE INJURED WORKER

When you've had an incident in the workplace, your first priority is getting care for the injured worker. **If your employee is unresponsive or severely injured, call 911.** If not, call our **24/7 NurseAid Work Injury Line** at 1.800.442.0593, which will give you instant access to a medical professional to help you choose your best next steps.

If medication is needed, share the ***Pharmacy Coupon*** with the injured worker to cover the cost of their first prescription fill.

If an employee does not seek immediate medical treatment or refuses medical treatment, complete the ***Declination of Medical Treatment*** and submit to MEM. **Applicable to Missouri policyholders only.**

If you currently have an Argonaut policy, our telehealth services are also available to you.

☐ REPORT THE CLAIM

After you've arranged care for the injured worker, you must report the claim to MEM. If your incident involves a fatality, hospitalization, or severe injury, call **1.800.442.0593** and select option 2 in the claims menu to report a claim after hours.

If not, choose one of the following reporting options:

- File an ***eClaim*** on the portal.
- Submit a claim over the phone at **1.800.442.0593**.
- Fax your claim to **1.800.442.0597**.

You are required to notify OSHA in the following situations:

- Fatality (Must be reported within 8 hours.)
- Loss of an eye (Must be reported within 24 hours.)
- Amputation (Must be reported within 24 hours.)
- In-patient hospitalization (Must be reported within 24 hours.)

Call the OSHA 24-hour hotline at **1.800.321.6742**. Have a description of the event, a contact person and phone number available. **The injury reporting process to MEM must begin within 5 days of the incident**, so start as soon as you can.

☐ DOWNLOAD THE INJURY REPORTING FORMS

Visit our ***Virtual Claims Kit*** to download the forms you need to report a workplace injury in your state. On the map, select a state listed on your policy. Navigate to Forms and locate the state-specific report of injury form.

2 WHAT TO DO AFTER AN INJURY OCCURS

REVIEW THE INJURY REPORTING PROCESS WITH YOUR EMPLOYEE

Review the injury reporting process with your employee as soon as possible. Be sure to discuss and document details regarding any upcoming medical appointments.

PERFORM AN INCIDENT INVESTIGATION

After your employee has received medical care, conduct an ***Incident Investigation Report***. Take photos of the scene if possible and have witnesses write down what they remember while details are still fresh. Complete the following forms and share them with MEM:

- ***Employee Incident Report***
- ***Incident Witness Statement***
- ***Incident Investigation Report***
- ***Incident Corrective Action***

GET A POST-INCIDENT SCREENING

If an incident has occurred in your workplace, it's important to know if drugs or alcohol were involved. In the state of Missouri, you have just 24 hours to test after an incident occurs. Take the employee to a certified testing facility, or use a ***self-administered drug test***. Visit orasure.com for testing options.

CREATE A RETURN TO WORK PROGRAM

For injured workers, getting back on the job can be their first priority — often before they've had enough time to recover. If you haven't created one already, developing a ***return to work program*** shows your employees you are committed to getting them back to work. Help injured workers get back on their feet by offering light duty options, such as administrative work or filing papers. Complete the ***Return to Work Requirements*** to determine what duties can be completed safely.

AVOID WORK COMP FRAUD

Workers compensation fraud affects everyone involved, and we want to help prevent it. If you suspect fraud in your workplace, be sure to report it by completing the ***form*** on our website. Our special investigative unit partners with policyholders and agents to detect and prevent workers compensation fraud and abuse.

Resources can be found online at mem-ins.com

Incident Forms

Previsor INSURANCE | MEM MISSOURI EMPLOYERS MUTUAL

EMPLOYEE INCIDENT REPORT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

TO BE COMPLETED BY EMPLOYER

NAME OF INJURED EMPLOYEE	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
DEPARTMENT		JOB TITLE	HIRE DATE
JOB PERFORMED		SUPERVISOR	
EMPLOYER		MEM POLICY#	
EMPLOYER CONTACT NAME		EMPLOYER TELEPHONE #	
INCIDENT LOCATION			
EXTENT OF INJURY		TREATING MEDICAL FACILITY	
BODY PART INJURED ❒ NO INJURY ❒ FIRST AID ONLY ❒ TAKEN TO CLINIC ❒ TAKEN TO ER ❒ FATALITY			

TO BE COMPLETED BY INJURED EMPLOYEE IF POSSIBLE

DESCRIPTION OF INCIDENT			
ANY OTHER WITNESSES? ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
WERE THERE OTHERS INJURED?	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #

REPORT COMPLETED BY	SIGNATURE	DATE
TITLE	PHONE NUMBER	

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

EMPLOYEE INCIDENT REPORT

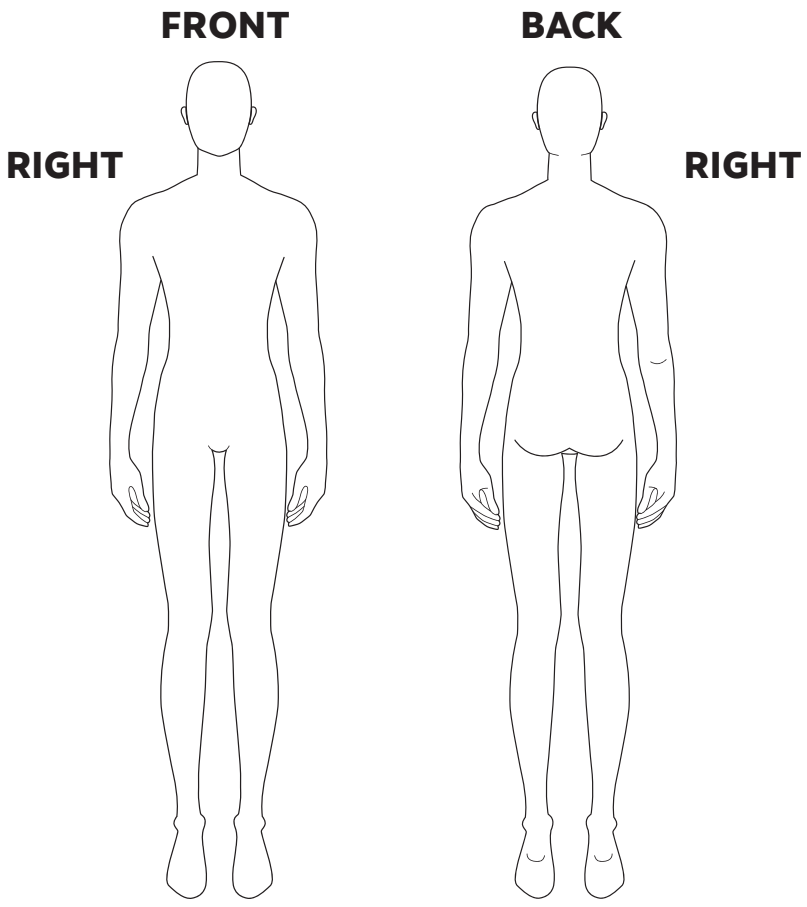
THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

NAME: _____ DATE: _____

DEPARTMENT: _____ JOB TITLE: _____

Mark the areas of the body where you feel the described sensations with the appropriate symbols from the chart below.

NUMBNESS	+ + + + +	SHARP	/ / / / /
BURNING	x x x x x	DULL & ACHING	* * * * *
PINS & NEEDLES	0 0 0 0 0	WEAKNESS	# # # # #



Indicate pain level below

NONE SLIGHT MODERATE SEVERE UNBEARABLE

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

TITLE: _____

INCIDENT WITNESS STATEMENT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

NAME OF WITNESS	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
DEPARTMENT	JOB TITLE		HIRE DATE
EMPLOYER (IF NOT AN EMPLOYEE)	PHONE # (IF NOT AN EMPLOYEE)		NAME OF SUPERVISOR
LOCATION OF INCIDENT			
NAME OF INJURED EMPLOYEE			
NAME OF INJURED EMPLOYEE'S EMPLOYER/MEM POLICY #	EMPLOYER'S PHONE #		
DESCRIPTION OF INCIDENT			
PHYSICAL CONDITIONS AT THE TIME OF INCIDENT			
ANY OTHER WITNESSES ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
REPORT COMPLETED BY	SIGNATURE		DATE
TITLE	EMPLOYER		

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

WORK COMP DECLINATION OF MEDICAL TREATMENT

APPLICABLE FOR MISSOURI POLICYHOLDERS ONLY

DATE: _____

Employer Information

EMPLOYER: _____

TREATMENT AUTHORIZED BY: _____

TITLE: _____

PHONE NUMBER: _____

Injured Worker Information

EMPLOYEE: _____ SOCIAL SECURITY NUMBER: _____

TITLE: _____

DEPARTMENT: _____ LOCATION: _____

DATE OF INJURY: _____ BODY PART INJURED: _____

Treatment Declination

I am declining my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on _____ (today's date). I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense.*

I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

EMPLOYEE SIGNATURE: _____ DATE: _____

If the employee desires, they shall have the right to select their own physician, surgeon, or other such requirement at their own expense. Section 287.140.1

REMARKS: _____

_____

Submit completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

Injured Worker Pharmacy Coupon

*Missouri Employers Mutual and Previsor Insurance make it possible for injured workers to obtain necessary medicine(s) without incurring out-of-pocket expenses. This coupon is valid for **only** the **first fill** of prescriptions required due to a workplace injury. It is only authorized for the injured worker referenced on this coupon and is non-transferable.*

Injured Worker Information

- This is a workers compensation claim.
- Insurance carrier: Missouri Employers Mutual/Previsor Insurance
- Employer name: _____
- Date of injury: _____
- Date of birth: _____
- SSN: _____

Pharmacy Instructions

This program guarantees payment for **only** the **first fill** of the prescription up to 10 days. Please confirm the injured worker has notified their employer so a pharmacy card may be issued for subsequent prescriptions.

Member ID

- To generate the Member ID for the first fill of the prescription, use the injured worker's 9-digit SSN plus 8-digit date of injury as their 17-digit member identification number: XXXXXXXXXMMDDYYYY
- BIN NO: 004336
- RX PCN: ADV
- RX Group No: RXFFWC225

Future Prescriptions

- If the injured worker does not present a MEM or Previsor Insurance pharmacy card, confirm eligibility by calling 1.800.442.0593.
- Consult with treating physicians to address perceived inadequacies or excesses of care.

Claim Processing

- For claim processing assistance, contact CorVel Pharmacy Solutions at 1.800.563.8438.

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1.800.442.0593

INCIDENT INVESTIGATION REPORT

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

THIS REPORT TO BE COMPLETED BY EMPLOYER.

NAME OF INJURED EMPLOYEE	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
JOB TITLE/DEPARTMENT			HIRE DATE
EMPLOYER		MEM POLICY NO.	
EMPLOYER CONTACT NAME		EMPLOYER TELEPHONE #	
JOB PERFORMED		EXPERIENCE PERFORMING JOB	
LOCATION OF INCIDENT		PERSON INCIDENT WAS REPORTED TO	
EXTENT OF INJURY ❒ NO INJURY ❒ FIRST AID ONLY ❒ TAKEN TO CLINIC ❒ TAKEN TO ER ❒ FATALITY		TREATING MEDICAL FACILITY	
DESCRIPTION OF INCIDENT			

ANY WITNESSES? ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
WERE THERE OTHERS INJURED? ❒ YES ❒ NO	NAME & PHONE #	NAME & PHONE #	NAME & PHONE #
WAS THERE PHYSICAL DAMAGE?			
CAUSE OF INCIDENT			

CONTRIBUTING INCIDENT FACTORS

Physical

- ❒ Poor housekeeping
- ❒ Poor or no equipment guarding
- ❒ Improper Illumination
- ❒ Improper ventilation
- ❒ Equipment failure
- ❒ Unsafe apparel
- ❒ Medical condition (e.g. stroke, cardiac arrest)
- ❒ Surrounding subcontractor at fault
- ❒ Conditions e.g. wet
- ❒ Other _____
- ❒ Other _____

Behavioral

- ❒ Not using required PPE
- ❒ Performing duties outside of scope of job
- ❒ Failure to obey supervisor's instructions
- ❒ Failure to obey job procedures
- ❒ Suspected intoxication
- ❒ Employee was engaged in horseplay
- ❒ Employee was unsuited for the job
- ❒ Other _____
- ❒ Other _____
- ❒ Other _____
- ❒ Other _____

Procedural

- ❒ Asked to perform job without training
- ❒ Operating equipment without training
- ❒ Poor enforcement of PPE use
- ❒ Needed equipment not supplied
- ❒ Failure to inspect equipment
- ❒ Failure to correct poor procedures
- ❒ Wrong equipment for the operation
- ❒ Wrong chemical or other used
- ❒ No pre-site inspection
- ❒ Other _____
- ❒ Other _____

REPORT COMPLETED BY	SIGNATURE	DATE
TITLE/EMPLOYER	PHONE #	

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

INCIDENT CORRECTIVE ACTION

THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT MEM-INS.COM OR BY CALLING 1.800.442.0593.

EMPLOYEE NAME OR INCIDENT REFERENCE	DATE OF INCIDENT	TIME OF INCIDENT _____ ❒ A.M. ❒ P.M.	DATE REPORTED
EMPLOYER		MEM POLICY #	
EMPLOYER CONTACT NAME		EMPLOYER TELEPHONE #	
LOCATION OF INCIDENT			
BRIEF DESCRIPTION OF INCIDENT			
DO YOU KNOW OF ANY SIMILAR INCIDENTS OCCURING IN THE PAST? ❒ YES ❒ NO IF YES, PLEASE DESCRIBE INCIDENTS.			
CORRECTIVE ACTION			
DATE CORRECTIVE ACTION COMPLETED		CORRECTIVE ACTION PERFORMED BY	
CORRECTIVE ACTION REFERENCE NUMBER (E.G. WORK ORDER, P.O. OR ACCOUNT NUMBER)			
FOLLOW UP ACTION REQUIRED			
FOLLOW UP ACTION TO BE COMPLETED BY			
REPORT COMPLETED BY		SIGNATURE	
TITLE		DATE	

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

Authorization to Obtain Information

I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer who has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to Missouri Employers Mutual Insurance, its employees, reinsurers, any designated Managed Care Organization, and the Division of Workers' Compensation to which I am submitting a claim.

I UNDERSTAND that the information obtained by use of this authorization will be used by the company to determine eligibility for workers compensation benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law. The release of my Protected Health Information to a person or organization not subject to federal law governing privacy, which then rediscloses my Protected Health Information, may mean that the protections afforded by the federal privacy laws no longer apply.

I UNDERSTAND the information contained in these records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and drug or alcohol use or abuse. **I HEREBY CONSENT AND AUTHORIZE** the medical record provider to release and provide records containing this information to Missouri Employers Mutual Insurance.

I AUTHORIZE MEM to discuss my health information with my authorized treating physician, evaluating physician and/or medical care provider and with my Employer and their representatives and agents for the purpose of managing and adjudicating my workers compensation case(s).

I KNOW that I may request to receive a copy of this authorization.

I AGREE that a photocopy of this authorization shall be as valid as the original.

I AGREE that this authorization shall be valid for the duration of this claim, unless I choose to withdraw this authorization in writing.

PRINTED NAME OF INJURED WORKER: _____ DATE: _____

SIGNATURE OF INJURED WORKER OR AUTHORIZED REPRESENTATIVE: _____

*** Note to record provider:**
The Health Insurance Portability and Accountability Act (HIPAA) expressly indicates that a patient's consent or authorization is not required for records to be disclosed when the request is made pursuant to workers compensation laws. See 45 CFR Section 164.512(1). This request for records is made pursuant to The Missouri Workers' Compensation Act, Section 287.140 RSMo., subsection 7 and Section 287.210 RSMo., subsections 5 and 6.

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

Autorización Para Obtener Información

AUTORIZO a cualquier médico matriculado, médico clínico, enfermera, farmacéutico, hospital, clínica u otra institución médica o relacionada con la medicina, compañía de seguros o reaseguros, agencia de información sobre el consumidor, empleador o ex empleador que cuente con algún dato sobre el diagnóstico, tratamiento o pronóstico de cualquier condición física o mental referida a mi persona y cualquier dato con respecto a mi profesión y salario, a brindar tal información a Missouri Employers Mutual Insurance (Compañía de Seguros Mutuos de Empleadores de Missouri), sus empleados, asesores de empleados/aseguradores, reaseguradores, cualquier Organización de cuidados administrados de salud y la División de Compensación al trabajador ante la cual estoy presentando un reclamo.

ENTIENDO que la información obtenida mediante esta autorización será utilizada por la compañía para determinar mi elegibilidad para recibir los beneficios de Compensación al trabajador. Cualquier información obtenida no será revelada a ninguna persona u organización excepto a otras personas u organizaciones que desempeñen un servicio legal o comercial relacionado con mi reclamo, o bajo otras circunstancias, conforme a lo permitido o requerido por la ley. La divulgación de mi Información de Salud Protegida (PHI) a una persona u organización no sujeta a la ley federal sobre privacidad, que luego vuelva a revelar mi Información de Salud Protegida, puede implicar que las protecciones otorgadas por las leyes federales sobre privacidad ya no sean aplicables.

ENTIENDO que la información contenida en estos registros puede incluir información relacionada con enfermedades de transmisión sexual, el síndrome de inmunodeficiencia adquirida (SIDA) o el virus de la inmunodeficiencia humana (VIH). También puede incluir información sobre servicios de salud mental o del comportamiento y el uso o abuso de drogas o alcohol. **POR EL PRESENTE ACEPTO Y AUTORIZO** al proveedor de registros médicos a divulgar y brindar registros que contengan esta información a Missouri Employers Mutual Insurance.

AUTORIZO MEM para hablar de mi información de salud con mi médico autorizado el tratamiento, el médico de la evaluación y / o proveedor de atención médica y con mi empleador y sus representantes y agentes a los efectos de la gestión y la resolución de mi caso, la remuneración del trabajador(s).

SOY CONSCIENTE que puedo solicitar que me envíen una copia de esta autorización.

DOY MI CONSENTIMIENTO para que la fotocopia de esta autorización tenga la misma validez que el original.

DOY MI CONSENTIMIENTO para que la presente autorización tenga validez durante el período de este reclamo, a menos que yo decida anular esta autorización por escrito.

ESCRIBA EN LETRA DE MOLDE EL NOMBRE DEL TRABAJADOR LESIONADO: _____

FIRMA DEL TRABAJADOR LESIONADO O DE SU REPRESENTANTE AUTORIZADO: _____

DATE:_____

*** Nota al proveedor de registros médicos:**
La Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA) indica expresamente que no se requiere consentimiento o autorización de un paciente para divulgar los registros cuando la solicitud se efectúa de acuerdo con las leyes sobre Compensación al trabajador. Véase 45 CFR Artículo 164.512(1). Este pedido de registros se efectúa de acuerdo con la Ley de Compensación al trabajador de Missouri, Articulo 287.140 RSMo., inciso 7 y Artículo 287.210 RSMo., incisos 5 y 6.

Enviar el formulario completo a: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597
Email: claims@mem-ins.com

Authorization for Medical Treatment

DATE: _____

Employer Information

EMPLOYER: _____

_____

_____

TREATMENT AUTHORIZED BY: _____

TITLE: _____

TELEPHONE NUMBER: _____

Injured Worker Information

INJURED WORKER: _____ SOCIAL SECURITY NUMBER: _____

JOB TITLE: _____

DEPARTMENT: _____ LOCATION(S): _____

DATE OF INJURY: _____ BODY PART INJURED: _____

Work Comp Insurance Carrier: Missouri Employers Mutual Insurance: 1.800.442.0593

Treatment Authorization

Please check all that apply:

- ❒ Initial Evaluation and Treatment
  - ❒ Alcohol Screening
  - ❒ Drug Screening
- ❒ Return-to-Work Exam
- ❒ Per Telephone Instructions
- ❒ Other

Note to employers: *You must have a Drug and Alcohol Policy in place that complies with Missouri law prior to selecting drug and alcohol screening.*

REMARKS: _____

_____

Submit a copy of this completed form to MEM by fax at 1.800.442.0597 or email it to claims@mem-ins.com. Keep a copy of this form for your records and one for the treating physician.

RETURN TO WORK REQUIREMENTS

INJURED WORKER: _____

POLICYHOLDER NAME: _____ POLICY NUMBER: _____

DEPARTMENT: _____ JOB TITLE: _____

HOURS PER SHIFT: _____ DATE OF INJURY: _____

BASIC REQUIREMENTS

	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
Sitting	❒	❒	❒	❒	❒
Standing	❒	❒	❒	❒	❒
Walking	❒	❒	❒	❒	❒

Mobility

Lifting	❒	❒	❒	❒	❒
Bending	❒	❒	❒	❒	❒
Squatting	❒	❒	❒	❒	❒
Reaching	❒	❒	❒	❒	❒
Kneeling	❒	❒	❒	❒	❒
Pushing	❒	❒	❒	❒	❒
Pulling	❒	❒	❒	❒	❒

Lifting

0 to 10 lbs.	❒	❒	❒	❒	❒
11 to 25 lbs.	❒	❒	❒	❒	❒
26 to 50 lbs.	❒	❒	❒	❒	❒
51 to 75 lbs.	❒	❒	❒	❒	❒
76 to 100 lbs.	❒	❒	❒	❒	❒
100+ lbs.	❒	❒	❒	❒	❒

Repetitive Motion	Right Hand		Left Hand	
Dexterity	❒ yes	❒ no	❒ yes	❒ no
Grasping	❒ yes	❒ no	❒ yes	❒ no
Writing	❒ yes	❒ no	❒ yes	❒ no
Typing	❒ yes	❒ no	❒ yes	❒ no

OTHER PHYSICAL REQUIREMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMPLOYER REPRESENTATIVE SIGNATURE: _____ DATE: _____

EMPLOYER/INSURER CONTACT: _____

FOR EMPLOYER COMPLETION

RETURN TO WORK REQUIREMENTS

PATIENT: _____

PHYSICIAN: _____

DIAGNOSIS: _____

TREATMENT (needed for OSHA rules and placement)

❒ Narcotic analgesic ❒ Anti-inflammatory medication ❒ Sutures
❒ Physical therapy ❒ Other _____

I saw this patient on (date) _____ and based on the above description of the patient's current medical problem (check all that apply):

❒ Return to regular duty on (date) _____.
❒ Return to work on (date) _____ with restrictions:
❒ Temporary ❒ Permanent
❒ Off work until (date): _____.

Patient to be reevaluated: _____.

Condition

❒ Improved
❒ Symptoms worse
❒ Unchanged
❒ Not applicable

Total hours of work per day

❒ 4 hours ❒ 6 hours
❒ 8 hours ❒ 10 hours
❒ No restriction
❒ Other _____

❒ **Heavy work.** Lifting 50 lbs. frequently with occasional lifting and/or carrying objects weighing up to 100 lbs.

❒ **Medium—heavy work.** Lifting 40 lbs. frequently with occasional lifting and/or carrying of objects weighing up to 75 lbs.

❒ **Medium work.** Lifting 25 lbs. frequently with occasional lifting and/or carrying objects weighing up to 50 lbs.

❒ **Light—medium work.** Lifting 20 lbs. frequently with occasional lifting and/or carrying objects weighing up to 30 lbs.

❒ **Light work.** Lifting 10 lbs. frequently with occasional lifting and/or carrying objects weighing up to 20 lbs. Even though the weight lifted may be a negligible amount, this category would include a job that requires walking or standing to a significant degree or involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

❒ **Sedentary work.** Lifting 10 lbs. maximum and occasionally lifting and/or carrying such articles as files, light packages and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

BASIC REQUIREMENTS

❒ Not applicable	Continuously 67-100%	Frequently 34-66%	Occasionally 11-33%	Seldom 1-10%	Restricted 0%
Sit/drive	❒	❒	❒	❒	❒
Stand	❒	❒	❒	❒	❒
Walk	❒	❒	❒	❒	❒
Bend	❒	❒	❒	❒	❒
Twist	❒	❒	❒	❒	❒
Climb	❒	❒	❒	❒	❒
Squat	❒	❒	❒	❒	❒
Work overhead	❒	❒	❒	❒	❒
Work shoulder level	❒	❒	❒	❒	❒

Hand: Specify - Right (R); Left (L); Bilateral (B)

❒ Not applicable					
Grasp	❒	❒	❒	❒	❒
Pincher grip	❒	❒	❒	❒	❒
Reach	❒	❒	❒	❒	❒
Twist (wrist)	❒	❒	❒	❒	❒
Push/pull w/ hands	❒	❒	❒	❒	❒
Wrist flexion/extension	❒	❒	❒	❒	❒

Feet: Specify - Right (R); Left (L); Bilateral (B)

❒ Not applicable

Repetive movements as in operating foot controls/pull w/ hands

❒ ❒ ❒ ❒ ❒

❒ No exposure to moving machinery ❒ No exposure to unprotected heights
❒ Avoid wet work ❒ Avoid irritants (specify)

Patient referred to (physcian): _____

Other instructions and/or limitations: _____

_____

_____

_____

PHYSCIAN SIGNATURE: _____

DATE: _____ **TIME:** _____

FOR PHYSICIAN COMPLETION

REQUISITOS DE REGRESO AL TRABAJO

NOMBRE DEL TRABAJADOR LESIONADO: _____

NOMBRE DEL TITULAR DE LA PÓLIZA: _____ NÚMERO DE LA PÓLIZA: _____

DEPARTAMENTO: _____ OCUPACIÓN: _____

HORAS POR TURNO: _____ FECHA DE LA LESIÓN: _____

REQUISITOS BÁSICOS DEL TRABAJO

	Continuamente 67-100%	Frecuentemente 34-66%	Ocasionalmente 11-33%	Raramente 1-10%	Restringido 0%
Sentar	❒	❒	❒	❒	❒
Parar	❒	❒	❒	❒	❒
Caminar	❒	❒	❒	❒	❒

Movilidad

Levantamiento de peso	❒	❒	❒	❒	❒
Encorvar	❒	❒	❒	❒	❒
Agachar	❒	❒	❒	❒	❒
Alcanzar	❒	❒	❒	❒	❒
Arrodillar	❒	❒	❒	❒	❒
Empujar	❒	❒	❒	❒	❒
Jalar	❒	❒	❒	❒	❒

Levantamiento de peso

0 a 10 libras	❒	❒	❒	❒	❒
11 a 25 libras	❒	❒	❒	❒	❒
26 a 50 libras	❒	❒	❒	❒	❒
51 a 75 libras	❒	❒	❒	❒	❒
76 a 100 libras	❒	❒	❒	❒	❒
100+ libras	❒	❒	❒	❒	❒

Movimiento Repetitivo	Mano Derecha		Mano Izquierda	
Destreza	❒ sí	❒ no	❒ sí	❒ no
Agarrar	❒ sí	❒ no	❒ sí	❒ no
Escribir	❒ sí	❒ no	❒ sí	❒ no
Mecanografiar	❒ sí	❒ no	❒ sí	❒ no

OTROS REQUISITOS FÍSICOS

_____

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FIRMA DEL REPRESENTANTE DEL EMPLEADOR: _____ FECHA: _____

CONTACTO DEL EMPLEADOR/ASEGURADOR: _____

COMPLETADO POR EL EMPLEADOR

REQUISITOS DE REGRESO AL TRABAJO

PACIENTE: _____

MÉDICO: _____

DIAGNÓSTICO: _____

TRATAMIENTO (necesario para las reglas y la colocación de OSHA)

❒ Analgésico narcótico ❒ Medicamentos antiinflamatorios ❒ Suturas
❒ Terapia física ❒ Otro _____

Vi a este paciente el (fecha) _____ y basado en la descripción anterior del problema médico actual del paciente (marque todo lo que corresponda):

❒ Regreso al servicio regular el (fecha) _____.
❒ Regreso al trabajo el (fecha) _____ con restricciones:
❒ Temporario ❒ Permanente
❒ Alejado del trabajo hasta (fecha): _____.

Paciente a reevaluar: _____.

Condición

❒ Mejorado
❒ Los síntomas empeoran
❒ Sin alterar
❒ No aplica

Horas totales de trabajo por día

❒ 4 horas ❒ 6 horas
❒ 8 horas ❒ 10 horas
❒ Sin restricción
❒ Otro _____

❒ **Trabajo pesado.** Levantando 50 libras frecuentemente con levantamiento y/o transporte de objetos que pesan hasta 100 libras.

❒ **Trabajo medio—pesado.** Levantando 40 libras frecuentemente con levantamiento y/o transporte ocasional de objetos que pesan hasta 75 libras.

❒ **Trabajo medio.** Levantando 25 libras frecuentemente con levantamiento y/o transporte de objetos que pesan hasta 50 libras.

❒ **Trabajo ligero—medio.** Levantando 20 libras. frecuentemente con levantamiento y/o transporte de objetos que pesan hasta 30 libras.

❒ **Trabajo ligero.** Levantando 10 libras. frecuentemente con levantamiento y/o transporte de objetos que pesan hasta 20 lbs. Aunque el peso levantado sea de una cantidad insignificante, esta categoría incluiría un trabajo que requiere caminar o estar parado por mucho tiempo o implica estar sentado la mayor parte del tiempo y incluye empujar y tirar de los controles de brazos y/o piernas.

❒ **Trabajo sedentario.** Levantando 10 libras. como máximo y ocasional levantamiento y/o transporte de artículos tales como archivos, paquetes livianos y herramientas pequeñas. Aunque un trabajo sedentario se define como aquel que implica estar sentado, a menudo es necesario caminar y estar parado un poco. Los trabajos son sedentarios si solo se requiere caminar y estar parado ocasionalmente y se cumplen otros criterios sedentarios.

REQUERIMIENTOS BÁSICOS

	Continuamente 67-100%	Frecuentemente 34-66%	Ocasionalmente 11-33%	Rara vez 1-10%	Restringido 0%
❒ No aplicable					
Sentar/conducir	❒	❒	❒	❒	❒
Parar	❒	❒	❒	❒	❒
Caminar	❒	❒	❒	❒	❒
Encorvar	❒	❒	❒	❒	❒
Torcer	❒	❒	❒	❒	❒
Subir	❒	❒	❒	❒	❒
Agachar	❒	❒	❒	❒	❒
Trabajo por encima de la cabeza	❒	❒	❒	❒	❒
Trabajo a la altura de los hombros	❒	❒	❒	❒	❒

Mano: Especificar - Derecha (R); Izquierda (L); Bilaterales (B)

❒ No aplicable					
Agarrar	❒	❒	❒	❒	❒
Agarre de pinza	❒	❒	❒	❒	❒
Alcanzar	❒	❒	❒	❒	❒
Torcer (muñeca)	❒	❒	❒	❒	❒
Empujar/jalar con las manos	❒	❒	❒	❒	❒
Flexión/extensión de muñeca	❒	❒	❒	❒	❒

Pies: Especificar - Derecha (R); Izquierda (L); Bilaterales (B)

❒ No aplicable					
Movimientos repetitivos como en el funcionamiento de los controles de pie/tirar con las manos	❒	❒	❒	❒	❒

❒ Sin exposición a maquinaria en movimiento ❒ Sin exposición a alturas sin protección
❒ Evite el trabajo mojado ❒ Evitar irritantes (especificar)

Paciente referido (médico): _____

Otras instrucciones y/o limitaciones: _____

_____

_____

_____

FIRMA DEL MÉDICO: _____

FECHA: _____ **HORA:** _____

COMPLETADO POR EL MÉDICO