The Ohio Manufacturers' Association
WORKERS' COMPENSATION SERVICES

INVESTIGATE EVERY INCIDENT

WORKERS' COMPENSATION CLAIMS MANAGEMENT TOOLS FOR OHIO MANUFACTURERS

We've created a video that describes best practices in incident investigation. Search under Workers' Compensation Management in the OMA Video Library. My OMA login required. (Search under Workers' Compensation Management > Conducting an Effective Workers' Compensation Claim Investigation.)

1. Obtain witness and non-witness statements from appropriate parties.

Witness statements should be obtained as soon as possible following an injury and from only those individuals who were eye witnesses. Collecting witness statements from actual eye witnesses increases the credibility of the statements in the event they are used to defend your position at an Industrial Commission hearing.

Witness statements should include statements about:

- **WHO:** In addition to the injured worker, who else was present?
- **WHAT:** What did the witnesses see happen (include specific details, i.e., weight and height of objects, distance, machinery, etc.).
- **WHEN:** Date and time of injury. Include special circumstances, i.e., beginning of shift, after lunch or break.
- **WHERE:** The exact location of the accident, i.e., department, process line, vantage point – standing, sitting, walking, etc.
- **HOW:** How did the incident happen? Be specific regarding events leading up to the incident or immediately following.

Non-witness statements can be just as valuable even if the workers in the vicinity know nothing about the incident; their statements can substantiate workplace conditions that were or were not present. Statements can be taken from anyone in the area.

Witness and non-witness statements can be handwritten on any piece of paper. If statements are verbal, they can be typed and then signed by the witness. If a claim is questionable, that is, might be contested by any party, original signatures should be notarized when possible.

When all incidents and accidents are investigated in the same manner, whether or not an injury or medical attention was required at the time, the process is less likely to create an adversarial situation. Keep in mind the injured worker has two years in which to file a claim following an incident.

2. Complete an Incident Report.

See OMA's model Incident Report. This form has been reviewed by legal counsel from Dinsmore & Shohl LLP.

INCIDENT REPORT

PART 1 TO BE COMPLETED BY EMPLOYEE

Employee Name_____ SSN _____

Job Title _____ Department _____

Date of Accident _____ Time of Accident_____ AM / PM

What was your job assignment at time of injury? _____

In the space below, please describe what happened. What were you doing? What equipment, machinery or substances were involved? How were you injured? _____

_____

_____

_____

State the nature of injury *(i.e., cut, bruise, burn, sprain, etc.)* and the specific part of body injured *(i.e., right knee, left index finger, etc.)*

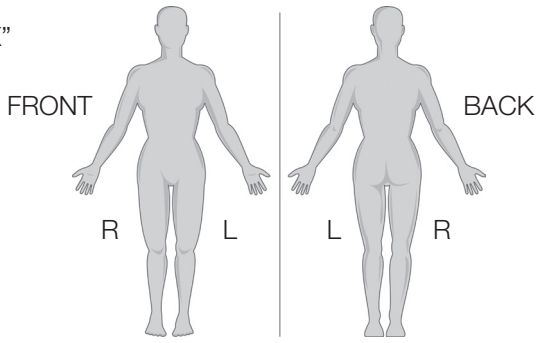
_____

_____

_____

_____

Mark part(s) of body injured with an "X"



Did you seek medical treatment? ❑ Y / ❑ N
If yes, when/where? _____

Have you ever injured this body part(s) previously? ❑ Y / ❑ N
If yes, give details (when/where/how/treating physician)

_____

List all witnesses to the incident that you are aware of:

_____

Did you report the incident to your supervisor ❑ Y / ❑ N
If yes, who did you report to? _____ Date reported_____/_____/_____
If no, why did you not report the incident? _____

_____

MEDICAL RELEASE:
I hereby authorize any medical provider to release all medical records pertaining to this injury and/or any prior treatment records to the areas of the body listed above, regardless of date of service.

Employee Signature _____ **Date** _____

INCIDENT REPORT

PART 2 TO BE COMPLETED BY IMMEDIATE SUPERVISOR & SAFETY DIRECTOR

IMMEDIATE SUPERVISOR TO COMPLETE

Employee Name_____ SSN _____

Date of Accident _____ Date Reported _____

Time of Accident _____ AM / PM

Date of Hire_____ Years on current job _____

Last Day Worked _____ Return-To-Work Date _____

Are pictures, sketches or video available? ❑ Y / ❑ N *(Attach)*

Witnesses to the incident? ❑ Y / ❑ N *(Attach statements)*

Was first-aid treatment given at the scene? ❑ Y / ❑ N / Offered but refused

Did employee seek medical treatment at an outside facility? ❑ Y / ❑ N

Incident Type *(Fall, Slip/Trip, Caught In/Under/Between, Struck Against, etc.):*

_____

Nature of Incident *(Bruise, Burn, Cut, Fracture, Sprain, etc.):*

_____

Body Part *(Head, Back, Internal, Lower Limb, Upper Limb, Torso, etc. – LEFT/RIGHT)*

_____

Equipment Involved: _____

Other factors involved *(Failure to follow procedures, skill ability deficiency, horseplay, housekeeping, equipment or tools, etc.)*

_____

_____

_____

Supervisor Signature _____ **Date** _____

SAFETY DIRECTOR TO COMPLETE

What action have you taken and/or do you plan to take to prevent recurrence? Enumerate actions and star (*) those already taken: _____

_____

_____

_____

What further recommendations or additional comments do you have?

_____

_____

_____

Safety Director Signature _____ **Date** _____

3. Obtain a Medical Release

As soon as possible after an incident, collect a medical release from the injured worker in the event we would need to solicit medical records to better understand the injury/illness.

We recommend you routinely – on every injury/illness – obtain a Bureau of Workers' Compensation (BWC) Form C-101. Making this a standard operating procedure will help diminish any feelings about matters of privacy or harassment on behalf of the injured worker.

Click here to obtain BWC Form C-101.

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

*You can obtain this form online at **www.bwc.ohio.gov***

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury	Claim number
Address	City	State	Nine-digit ZIP code
Employer name	Employer MCO or QHP		

I, the above-named injured worker, understand I am allowing the Opportunities for Ohioans with Disabilities and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

  _____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.