ESCO GROUP

ATTENTION ALL EMPLOYEES
Worker's Compensation
Medical Treatment Facilities

The following medical treatment centers are the designated workers' compensation treatment centers. You will receive priority treatment at any of the following facilities when you take your authorization form with you. This will assist staff in your care and in the processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know that you are on your way for medical treatment and the nature of the illness or injury.

If you need medical treatment due to a work related injury/illness in Marion area seek treatment at either:
Unity Point/St Luke's Work Well Clinic
830 1st Avenue NE
Cedar Rapids, IA 52406
(319) 369-7173
Monday - Friday: 7:00am – 5:00pm

For SERIOUS INJURY OR ILLNESS seek treatment at either:
(ANY TREATMENT THAT SHOULD NOT WAIT UNTIL CLINIC HOURS THE NEXT DAY)

Preferred:		
Unity Point/St Luke's Hospital		**Mercy**
Medical Center		
1026 A. Avenue NE		701 10th
Street SE		
Cedar Rapids, IA. 52406		Cedar Rapids,
IA. 52403		
(319) 369-7105	(319) 398-6037	
24-Hour Service		24-Hour
Service		

For **FOLLOW-UP-CARE** of a work related injury or illness, seek treatment at.

Unity Point/St Luke's Work Well Clinic
830 1st Avenue NE
Cedar Rapids, IA. 52406
(319) 369-8153
Monday – Friday: 7:00am – 5:00pm

If you need medical treatment due to work related injury/illness in the **Des Moines** area, seek treatment at:
Non-Emergency: Concentra Medical Center

Emergency: Iowa Lutheran Hospital

2100 Dixon Street, Suite E

700 E University Ave.

Des Moines, IA 50316

Des Moines, IA 50316

(515) 265-1020

(515) 263-5612

8:00AM to 5 PM Weekdays

24 Hour Service

If you need medical treatment due to a work related injury/illness in the Muscatine area seek treatment at:
Non-Emergency: Trinity Muscatine Occupational Medicine

Emergency: Trinity Muscatine

1616 Cedar Street (Upper Level)

1518 Mulberry Ave

Muscatine, IA 52761

Muscatine, IA 52761

(563) 262-4120

(563) 264-9100

Weekdays: 8:00am – 12:00pm 1:00 pm-5:00 pm

24 Hour Service

If you need medical treatment due to a work related injury/illness in the Fort Dodge area seek treatment at:

Non- Emergency: Trinity Corporate Health Services

Emergency: Trinity Regional Medical Center

2520 9th Ave S.

Fort Dodge, IA 50501

(515) 574-6810

Weekdays: 8:00am – 5:00pm

802 Kenyon Rd.

Fort Dodge, IA 50501

(515) 573-3101

24 Hour Service

If you have any questions regarding this procedure, please call your workers' compensation coordinator. **Quincey Luedeman** Office (319) 377-6655 Cell (319) 350-2458

ESCO GROUP
INSTRUCTION FOR INJURED EMPLOYEE

"What do I do if I have a work related injury or illness"

Take the workers' compensation authorization form (page 1) of this packet to the designated physician/facility with you. This will assist in your care and the billing process for you medical expense.

Have someone call the designated physician/facility to alert staff of your injury, and your approximate arrival time.

"Who pays for the medical treatment?"

All medical bills relating to this claim should be sent to your workers' compensation coordinator within 48 hours of your work related injury.

Do not use your health membership card if this injury/illness was sustained while working or acting in an official capacity for this company.

"Who completes the employee's work injury report?"

You are responsible for answering all questions on the employee's work injury report accurately, and in detail. This will make processing of your claim both accurate and timely. This report should be given to the workers' compensation coordinator within 24 hours of your work related injury or 6 hours if 3 or more employees were injured. Call IMMEDIATELY if we have a death of an employee.

"What do I do with the Supervisor's Instructions and Supervisor's Investigation Report?'

You should give both documents to your supervisor immediately and relate to him/her the details of your work related injury/illness.

"What should I do if I have further questions or concerns?"

Be sure to contact your workers' compensation coordinator.

ESCO GROUP EMPLOYEE'S WORK INJURY REPORT

Employee Name: First _____ MI____ Last_____
Date of Birth _____ Gender (check one) _____M _____F
Mailing Address _____
City _____ State _____ Zip Code _____
Phone # _____ Cell Phone # (Optional) _____

Marital Status: ___ Single ___Married ___ Separated
Tax Filing Status: ___ Single (A) ___Single/Head of Household (B)
___Married/Filing Joint (C) ___Married/Filing Separate (D)
Number of Dependents ____ Number of Exemptions _____ Entitled _____Withholding _____

Occupation Description _____

Date of Hire _____ Department Where Regularly Worked_____

Education Level _____

Average Wage $_____(check one)
___ Hourly ___ Daily ___Bi-Weekly ___Weekly ___ Annual ___Semi-Monthly ___Monthly
Number of Days Regularly Worked Per Week_____

Employee ID Number _____ (check one) ___Social Security # ___Employment VISA # ___ Passport # ___ Green Card ___ Employee ID Assigned by Jurisdiction
Employee's Authorization to Release the Following: Medical Records ___ Yes ___ No Social Security # ___ Yes ___ No
Employment Status: (check one) ___ Piece Worker ___ Volunteer ___Seasonal ___ Apprenticeship/part-time ___ Apprenticeship/full-time ___ Regular Employee/full-time ___Part-time ___Other
Salary Continued in Lieu of Compensation: ___Yes ___No
Full Wages Paid for Date of Injury: ___ Yes ___ No
Discontinued Fringe Benefits: $_____

Initial medical provider name: _____

Initial medical provider address, City, State and Zip_____

Describe the nature of the injury_____

Parts of the body directly affected by the injury or illness
_____
Describe the events that caused the injury
_____
Name the object or substance that directly injured the employee
_____
Specify activity the employee was engaged in when the event occurred_____

_____

Witness name and business phone number

_____

Date of injury:
Date Employer had knowledge of the injury:
Date claim administrator had knowledge of the injury:
Initial date last day worked:
Initial return to work date:
Employee date of death:
Time of injury:
Time employee began work:
Pre-existing disability code: Yes ____ No ____ Unknown ____
Initial treatment code: ____no medical treatment (0) ____ minor/onsite treatment (1) ____ clinic/hospital visit (2) ____ emergency Care (3) ____ hospitalization-24 hours (4) ____ future medical treatment/lost time anticipated (5)
Accident premises code: ___Employer (E) ___ Lessee (L) ___ Other (X)
Accident site organization name:
Accident site Street, City, State & Zip Code:
Accident location narrative: (if no street address)
Accident Site County/Parish:

Employee Signature _____Date _____

This report should be given to the Worker's Compensation coordinator within 24 hours of your work related injury.

ESCO GROUP
SUPERVISOR'S INSTRUCTIONS

ASSISTING THE INJURED EMPLOYEE

The following steps should be taken in order to better assist the employee after he/she has been injured or becomes ill.

1. Remind the injured employee to go to the designated physician or treatment center.

2. Emphasize that only injuries/illnesses that are serious or need treatment after regular clinic hours should be treated at a hospital emergency center.

3. Call the designated physician or medical treatment center prior to the employee's arrival. Alert the staff of the injury/illness and approximate time of arrival.

THE INVESTIGATION REPORT

The purpose of this form is to determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide your staff in developing safety consciousness and knowledge of safe conditions and safe work methods. If you are not aware of the circumstances surrounding the injury, you should consult with the employee in order to
complete the investigation report accurately.

The statements made in this report are very important and should not contain certain phrases such as "Employee should be more careful". As the supervisor, you should make the appropriate corrective recommendations for each accident, such as, "Notified the appropriate employee to place caution sign in area when floors are wet".

After you complete the investigation report, return it to the workers' compensation coordinator within 48 hours of the employee's work related injury.

If you have questions or concerns, call the workers' compensation coordinator.

ESCO GROUP
SUPERVISOR'S INVESTIGATION REPORT

Name of Injured Employee Date

Job Title and Department

Date and Time of Injury Type of Injury

Designated Medical Treatment Center

What was the Employee doing when injured? Where did the accident happen?

_____
_____
_____

Describe what happened? _

_____
_____
_____

What corrective steps will be done (or could be done) to prevent recurrence?

_____
_____
_____

Was the employee working on a designated job? Yes _____ No _____

Is there light duty available for the injured worker? Yes _____No _____

Supervisor's Signature Date

Reviewed by Workers' Compensation Coordinator Date

Comments: _____

_____

_____

_____

Return completed form within 48 hours of the accident.

ESCO SAFETY
An ESCO Group Company

Witness Statement Form

CONTACT INFORMATION

Name:_____ Employer:_____

Date of Incident:_____ Position:_____

Time of Incident:_____ Project:_____

WITNESS STATEMENT

Describe what you know about the accident – what you saw or heard, what you were doing before the accident, what you did after the accident (use other pages if necessary).

_____

_____

_____

_____

_____

_____

_____

_____

OTHER WITNESSES

Others with knowledge of the accident:

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

SIGNATURE

This statement is true to the best of my knowledge and memory:

Signature:_____ Date:_____