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
1026 A. Avenue NE
Cedar Rapids, IA. 52406
(319) 369-7105
24-Hour Service

Mercy Medical Center
701 10th Street SE
Cedar Rapids, IA. 52403
(319) 398-6037
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
2100 Dixon Street, Suite E
Des Moines, IA 50316
(515) 265-1020
8:00AM to 5 PM Weekdays

Emergency: Iowa Lutheran Hospital
700 E University Ave.
Des Moines, IA 50316
(515) 263-5612
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
1616 Cedar Street (Upper Level)
Muscatine, IA 52761
(563) 262-4120
Weekdays: 8:00am – 12:00pm 1:00 pm-5:00 pm

Emergency: Trinity Muscatine
1518 Mulberry Ave
Muscatine, IA 52761
(563) 264-9100
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
2520 9th Ave S.
Fort Dodge, IA 50501
(515) 574-6810
Weekdays: 8:00am – 5:00pm

Emergency: Trinity Regional Medical Center
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

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Instructions for Injured Employee

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

- Take the worker's compensation authorization form (Appendix 4) of this packet to the designated physician/facility with you. This will assist in your care and the billing process for your medical expense.

- Have someone call the designated physician/facility to alert the 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 worker's compensation coordinator within 48 hours of your work related injury.

- Do not use your group 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 (Appendix 6) accurately, and in detail. This will make processing of your claim both accurate and timely. This report should be given to the worker's 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 (Appendix 7) and Supervisor's Investigation Report?" (Appendix 8)

- You should give both documents to your supervisor immediately and relay 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 worker's compensation coordinator.

Automation Electric Engineering Safety Testing

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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.

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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 report accurately.

The statements made in this report are very important and should not contain 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 the 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.

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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: _____

_____