Employee Completes
HR to Keep

Employee Report of Injury

Name: _____ **Address:** _____
Phone #: _____ Birth Date: _____ Date of Hire: _____
Accident Occur on Premises: ☐ Yes ☐ No Detailed Location: _____
Date of Injury: _____ Time: _____ ☐ am ☐ pm Shift: _____
Date Reported: _____ **Witnesses:** _____

What were you doing just before incident occurred: _____

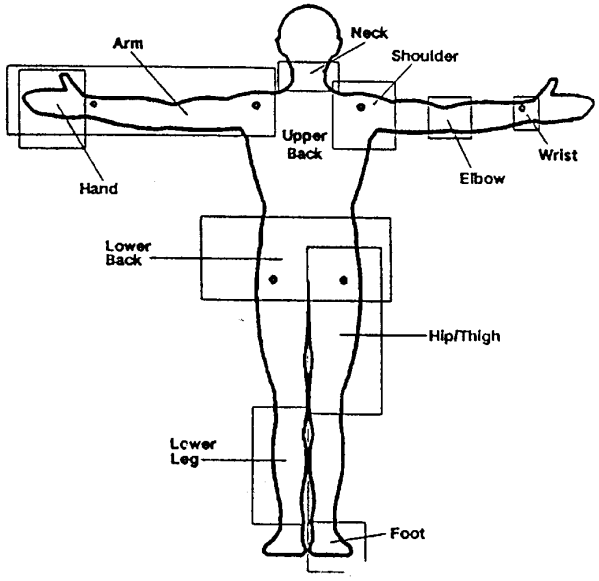
_____

Describe the accident in detail/what happened: _____

_____

What object or substance directly harmed the employee: _____

_____

Injured Area	Indicate Area of Injury	Type of Injury
1 ☐ Head 2 ☐ Eye: L/R 3 ☐ Shoulder L/R 4 ☐ Arm L/R 5 ☐ Elbow L/R 6 ☐ Wrist L/R 7 ☐ Hand L/R 8 ☐ Finger: Specify _____ 9 ☐ Back 10 ☐ Chest 11 ☐ Abdomen 12 ☐ Pelvis 13 ☐ Hip L/R 14 ☐ Leg L/R 15 ☐ Knee L/R 16 ☐ Ankle L/R 17 ☐ Foot L/R 18 ☐ Toe: Specify _____ 19 ☐ Other: _____	 **LEFT** **RIGHT**	1 ☐ Abrasion 2 ☐ Amputation 3 ☐ Bite: _____ 4 ☐ Bruise 5 ☐ Burn 6 ☐ Concussion 7 ☐ Cut/Laceration 8 ☐ Foreign Body 9 ☐ Fracture 10 ☐ Hearing Impaired 11 ☐ Infection 12 ☐ Pain: _____ _____ 13 ☐ Puncture 14 ☐ Rash/Dermatitis 15 ☐ Respiratory 16 ☐ Strain/Sprain 17 ☐ Other: _____ _____

Employee's suggested action to prevent recurrence: _____

_____

Employee Signature: _____ Date: _____

IMMEDIATE ACTIONS: Prior to resuming work following incident:

Any unsafe conditions with equipment or process that caused accident: ☐ Yes ☐ No Supervisor Signature _____
If yes, list condition and corrective actions to eliminate the conditions: _____

_____

THIS PAGE MUST BE COMPLETED AND SUBMITTED PRIOR TO LEAVING YOUR SHIFT OR ASAP

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Employee Completes
HR to Keep

AUTHORIZATION FOR RELEASE OF RECORDS

(Source: HIPAA Privacy Regulations 45 C.F.R. 164.508)

Patient Name: _____ Patient Date of Birth: ____/____/____

I hereby authorize all of my medical providers, including all physicians, chiropractors, hospitals, clinics and all other healthcare providers and facilities, to disclose and release to an authorized representative of **West Bend Mutual Insurance Company,** all of the following samples and individually identifiable health information:

Any and all information and records relating to the diagnosis, treatment, care, evaluation, examination, transport, and payment for any condition, illness, or injury, including all:

- medical records, hospital records, nursing records, narrative reports, clinician office chart notes, physical therapy records, patient history, information sheets, prescriptions, correspondence, letters, opinion letters, and dental records;
- test data, test results, laboratory reports, pathology reports, diagnostic imaging reports (including x-rays, MRIs, and all other diagnostic films), and blood, urine, hair, and bodily fluid samples;
- billing statements, invoices, insurance records and forms, records of other health providers, and work excuses; and
- any other information and records relevant to my workers' compensation claim and/or work status, regardless of the date of such records and including records created after the date of this authorization.

By initialing below, I specifically authorize the release of all information and records relating to the following *(check all boxes that apply):*

☐ HIV/AIDS and other sexually transmitted disease diagnosis and treatment;

☐ Substance abuse (drug or alcohol) diagnosis and treatment, as well as all blood, urine, hair, and bodily fluid samples, from all health care providers and facilities and any other person or entity in possession of records concerning me; including Part 2 Program facilities subject to 42 C.F.R. § 2.31;

☐ Mental health diagnosis and treatment.

Purpose: The purpose of this authorization is to provide West Bend with information and documentation concerning my medical treatment and medical history in connection with the evaluation and investigation of a workers' compensation insurance claim.

Authorized Third Parties: I authorize the disclosure and release of all of the samples and individually identifiable health information identified above to the following third party vendor(s) of West Bend *(if none, leave blank):*

Expiration: This authorization shall expire upon the final resolution of my workers' compensation claim.

Revocation: I may revoke this authorization at any time by notifying West Bend in writing at P.O. Box 14856, Lexington, KY 40512-4856. I understand that any revocation shall be effective on the date it is received and will not have any effect on any actions taken prior to receipt. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services.

Re-Disclosure: I understand that any information that is disclosed pursuant to this authorization may be re-disclosed in accordance with federal law and potentially no longer covered by federal rules governing privacy of health information.

A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient

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Employee Completes
HR to Keep

Declination of Treatment

It is our policy to provide prompt and appropriate medical treatment to employees for work-related injuries. There are situations that arise where notice of an injury may be made, and formal treatment is not necessary.

When an employee reports a work-related injury, the injury will be documented and treatment will be offered. An employee may indicate a preference not to have formal medical treatment. In the event that an employee declines medical treatment, we will have the employee sign this document indicating that they declined medical treatment. The company will continue to monitor the resolution of the complaints or injury until the time that the condition has been completely resolved. The employee will be asked to sign off that the condition has completely resolved.

In the event that a condition is not improving readily during the monitoring period, or should the condition worsen, the employee will be sent for an evaluation to make sure the condition is properly addressed. There may be situations where an employee is sent for a medical clearance examination following their report of injury, even though the injured employee has declined medical treatment.

Date of Injury: _____

Injured Employee's Name: _____

Supervisor's Name: _____

Body Part(s) Injured: _____

☐ **I am declining medical treatment at this time. Should my condition worsen, or should I change my mind regarding treatment, I know I must inform my supervisor immediately.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

☐ **My injury/injuries have completely resolved.** Date: _____

Injured Employee's Signature: _____

Supervisor's Signature: _____

Employee to Keep

myMatrixx® by Evernorth

Workers' Compensation Temporary Prescription ID Card

Tarjeta de identificación temporal para medicamentos con recetas de compensación de los trabajadores

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).
Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 877-804-4900.

To the Pharmacist:

myMatrixx, by Evernorth administers this workers' compensation prescription program. Please follow the steps below to submit a claim.
Standard claim limitations include

- Quantity exceeding 30 pills
- Day supply exceeding 30 days
- Dollar amount exceeding $350
- Form is valid for up to 30 days from DOI
- Only specific medications allowed

For assistance, call myMatrixx at 877-804-4900.

Pharmacy Processing Steps

Step 1: Enter bin number 003858
Step 2: Enter processor control WC
Step 3: Enter the group number as it appears above
Step 4: Enter the injured worker's nine-digit ID number
Step 5: Enter the injured worker's first and last name
Step 6: Enter the injured worker's date of injury

Para el trabajador lesionado:
En la primera visita, entregue este aviso a cualquiera de las farmacias que se indican al dorso para agilizar el procesamiento de las recetas aprobadas de compensación de los trabajadores (según las pautas establecidas por el empleador).

¿Tiene preguntas o necesita ayuda para localizar alguna de las farmacias que participan en la red de venta al por menor? Llame al Centro de contacto para la atención al paciente de Express Scripts al 877-804-4900.

Para el farmacéutico:
Express Scripts administra este programa de medicamentos con recetas de compensación de los trabajadores. Siga los pasos indicados a continuación para presentar una reclamación.
Las limitaciones para una reclamación estándarincluyen:

- La cantidad supera las 150 pastillas
- Elsuministro diario supera los 14 días
- El monto en dólares supera los $150
- Este formulario es válido por hasta 30 días desde la fecha de la lesión (DOI).
- Solo se permiten medicamentos específicos.

Para asistencia, llame a Express Scripts al 877-804-4900.

Pasos de procesamiento de la farmacia
Paso 1: Ingrese el número de ubicación 003858
Paso 2: Ingrese el procesador de control WC
Paso 3: Ingrese el número de grupo como aparece arriba

Paso 4: Ingrese el número de identificación de nueve dígitos del trabajador lesionado
Paso 5: Ingrese el nombre y el apellido del trabajador lesionado
Paso 6: Ingrese la fecha de la lesión del trabajador lesionado

WEST BEND®

myMatrixx, by Evernorth

ID# (N.o de identificación): _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.
El n.° de Seguro Social (SSN) es su número de identificación temporal. Recibirá un nuevo número de identificación a la brevedad.

Date of Injury: _____/_____/_____
Fecha de la lesion MM/DD/YYYY

Group #: P4UA
N.° de grupo

Employee Date of Birth: _____/_____/_____
Fecha de nacimiento (DOB) del empleado

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare. *Please see other side for a list of participating retail network pharmacies.*

Gracias por usar una farmacia que participa en la red de venta al por menor. Si bien no tiene que pagar ningún costo directo, es importante que todos colaboremos para ayudar a controlar el aumento de los costos de atención médica. Consulte el dorso para obtener una lista de las farmacias que participan en la red de venta al por menor.

To the Supervisor:

Please fill in the information requested for the injured worker.

Para elsupervisor: Complete la información solicitada para el trabajador lesionado.

Employee Information (Información del empleado)

_____ _____ _____
First (Nombre) M (2.°) Last (Apellido)

_____
Street Address or PO Box (Dirección o casilla de correo)

_____ _____ _____
City (Ciudad) State (Estado) ZIP (Código postal)

Employer Name (Nombre del empleador)

Hawkeye Area Community Action Program (HACAP)

CRP1806_0245 EME46657 OT48017I

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Workers' Compensation Temporary Prescription ID Card

Tarjeta de identificación temporal para medicamentos con recetas de compensación de los trabajadores

myMatrixx by Evernorth

Participating Retail Network Pharmacies - Farmacias que participant en la red de venta al por menor

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

CRP1806_0245 EME46657 OT48017I

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Supervisor or On-Site Supervisor Completes
HR to Keep

Management Accident Investigation Report

Employee	Dept.	Job Title
Shift:	Date of Injury Time AM or PM	
Location of Incident		
Date Reported / / Time Reported	Reported to Whom?	

NAME OF WITNESS	DEPARTMENT/ADDRESS	PHONE
(1)		
(2)		

Have witnesses fill out separate forms and give attach.

1. What was employee doing when injured? BE SPECIFIC

2. How did the injury/illness occur?

3. Was employee performing function alone? ☐ yes ☐ no

Employee was assisting with the operations?

4. Did injury occur because of: Failure to follow safety rules ☐

Failure to use safety device ☐ Other ☐

5. How long has employee been doing this job? (days, months, years)

6. What safety equipment is required on the job the employee was performing?

7. Was the employee using all required safety equipment? Yes ☐ No ☐

8. If No, which specific personal protective equipment was not used & why?

9. Does an unsafe condition exist that contributed to the cause, if so, what is that condition?

10. How could the accident have been prevented? BE SPECIFIC

RECOMMENDED ACTION			**Person Responsible**	**Assigned Date/Completed Date**
Re-instruction	Yes ☐	No ☐	_____	_____/_____
Equipment repair/replacement	Yes ☐	No ☐	_____	_____/_____
Reduce Clutter	Yes ☐	No ☐	_____	_____/_____
Improve design/construction	Yes ☐	No ☐	_____	_____/_____
Workstation Modification	Yes ☐	No ☐	_____	_____/_____
Discipline of person(s) involved	Yes ☐	No ☐	_____	_____/_____
Other				

Signature of Person Completing Investigation: _____

Date: _____

Witness Completes
HR to Keep

WITNESS REPORT OF INCIDENT

Name: _____ Injured Employee Name: _____

Date of Injury: _____ Time of Accident: _____ (AM/PM)

Location where injury occurred:

_____

_____

_____

Describe activity prior to the accident:

_____

_____

_____

Describe the accident:

_____

_____

_____

What do you believe caused the accident:

_____

_____

_____

What part of the body was injured? _____

What do you think could prevent this type of accident from occurring again?

_____

_____

_____

Signed: _____ Date: _____

REVISED: 6/2025

SUPERVISOR TO KEEP

Work Comp Claims: Call Preparation Guide
1-800-236-5010 ext. 5247

Policy #: 1708158-14

Please have the following information prepared when reporting a claim:

Accident Information:
- Date and time of accident.
- Date injury/occurrence was reported to employer
- Time the accident was reported.
- To whom did the employee report the claim?
- Employee's supervisor.
- Accident location (street address, city and state).
- Does employer think the claim is questionable?
- What was the employee doing at time of the incident?
- Any other employees involved?
- Did the accident result in fatality?
- Number of days employee expected to lose because of accident.
- Last date employee worked.
- First full day of work employee missed due to accident
- Is employee receiving regular salary while off work due to injury?
- Has employee returned to work?
- Date employee returned to work.
- Any witness(es) to the accident?
- Name, address and phone number of witness(es).

Employee Information:
- Name.
- Social Security Number.
- Home phone number.
- Physical home address.
- County in which employee resides
- Date of birth.
- Gender.
- Regular occupation (job title).
- Department in which employee regularly works.
- Was employee injured in the course of their regular job?
- What language does the employee speak?
- State in which the employee was hired.

Medical Provider Information:
- Name of any doctor's office, clinic or hospital that treated the injured employee.
- Address any doctor's office, clinic or hospital that treated the injured employee.