|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Worker Related – REPORT OF INJURY OR ILLNESS**    **(Complete UNDERLINED Areas Only) Claim Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Budget Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **E**  **M**  **P**  **L**  **O**  **Y**  **E**  **E** | First Name | | | | | | | Middle Initial | | | | Last Name | | | | | | | | Social Security No. | | | | | Date of Birth | | |
|  | | | | | | |  | | | |  | | | | | | | |  | | | | |  | | |
| Mailing Address | | | | | | | | | | | City | | | | | | | | State | | | Zip Code | | Telephone Number | | |
|  | | | | | | | | | | |  | | | | | | | |  | | |  | |  | | |
| Marital Status | | | | | | | | | | | Employee Number of Dependents | | | | | | | | | | | | | Gender  M  F | | |
| Unmarried | | Married | | | Separated | | | | | |  | | | | | | | | | | | | |
| Are you currently eligible for Medicare? | | | | | | | | Yes | | | No | | | | | If yes, what is your Medicare # | | | | | | | | | | |
| Will you be eligible for Medicare in the next two years? | | | | | | | | Yes | | | No | | | | | If yes, what date will you be eligible for Medicare | | | | | | | | | | |
| **E**  **M**  **P**  **L**  **O**  **Y**  **M**  **E**  **N**  **T** | Job Title | | | | | | | | | | | Manager/Supervisor Name | | | | | | | | | | | | | Date of Hire | | |
|  | | | | | | | | | | |  | | | | | | | | | | | | |  | | |
| Department Where Regularly Worked | | | | | | | Employment Status | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Regular Full-Time | | | | | | Regular Part-Time | | | | | | | Seasonal/Temp/Intermittent | | | | | Volunteer | |
| Wage Rate | $ | | | | | | Number of Days Regularly Worked Per Week | | | | | | | | | | | | | | | | | | | |
| Per | Hour  Annually | | | | | |
| **A**  **C**  **C**  **I**  **D**  **E**  **N**  **T**  **/**  **I**  **N**  **J**  **U**  **R**  **Y** | Date of Accident/Injury¹ | | | Time of Accident/Injury | | | | | | | Time Employee Began Work | | | | | | | Witness (s) name (s) | | | | | | | | | |
|  | | |  | AM | |  | | PM | |  | | AM | |  | PM | |
| Describe in **FULL DETAIL** the nature of the Injury (ex: amputation, burn, cut, fracture). You must include the following information   1. Part(s) of body directly affected by the injury or illness 2. Full description of the events that caused the injury 3. Description of the object or substance that directly injured the employee (ex: knife, floor, acid, oil) 4. The specific activity the employee was engaged in when the event occurred (ex: cutting metal plate for flooring) Indicate if activity was part of normal duties | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accident Site Organization Name | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Accident Site Street, City, & Zip | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Accident Site Premises Code | | | | Employer (E) | | | | | | | | | | Lessee (L) | | | | | | | | | Other (X) | | | |
| Accident Location Narrative (if no street address available) | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Accident Site County | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **M**  **E**  **D**  **I**  **C**  **A**  **L** | Initial Treatment Code (check one) | | | | No Medical Treatment (0) | | | | | Minor/On-site treatment (1) | | | | | Clinic/Hospital Visit (2) | | | | Emergency Care (3) | | | | | Hospitalization > 24 hours (4) | | | Future medical treatment/lost time anticipated (5) |
| Initial Medical Provider Name | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Initial Medical Provider Physical Address, City, State & Zip | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Employee’s Signature | | | | | | | | | | | | | | | | | | | | | Date | | | | | |
| **🞏**  **This is a preliminary report (copy), signed either by the manager or the employee. Please forward a copy to Human Resources immediately**. | | | | | | | | | | | | | | **🞏 This is a final report (original), both the manager and the employee have verified the information as being accurate and correct** | | | | | | | | | | | | |
| **M**  **A**  **N**  **A**  **G**  **E**  **R** | **FATALITY: I must report this to OSHA within 8 hours.**  **Link to Report:** [**https://www.iowadivisionoflabor.gov/osha/safety/incident**](https://www.iowadivisionoflabor.gov/osha/safety/incident)  I, the signing manager below, have reported to OSHA within 8 hours due to a fatality | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **INPATIENT HOSPITAL STAY, A LOSS OF AN EYE, OR AN AMPUTATION WITH OR WITHOUT BONE LOSS: I must report this to OSHA within 24 hours.**  **Link to Report:** [**https://www.iowadivisionoflabor.gov/osha/safety/incident**](https://www.iowadivisionoflabor.gov/osha/safety/incident)  I, the signing manager below, have reported to OSHA within 24 hours | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Link to OSHA site to report events: [**https://www.iowadivisionoflabor.gov/osha/safety/incident**](https://www.iowadivisionoflabor.gov/osha/safety/incident) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **🞏 \*\*Before signing this form, managers are responsible for making sure all blanks are completed by the employee\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Manager’s Signature | | | | | | | | | | | | | | | | | | | | | Date | | | | | |

Employees must report on-the-job injuries to their manager immediately. This report is to be filed with Human Resources within 48 hours after the injury. Fill out this report, no matter how slight the injury may seem. Filling out this report does not obligate you to seek medical treatment.



AUTHORIZATION FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Patient’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: ( \_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize (List the medical facility(s) that have treated you for this injury)

MercyOne Des Moines Occupational Health Address 2525 East Euclid Avenue – Des Moines, IA 50317 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to use or disclose my health information, as described below. I further authorize the following individuals or organizations to receive my health information:

EMC Risk Services, LLC., and their affiliates and representatives, including legal counsel

The City of West Des Moines Human Resources Department

The purpose of the requested use or disclosure is:

⌧ Work Related Injury/Illness At the request of the individual

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The information to be used or disclosed includes the following specified information:

X Discharge Summary X Consultation Reports X Radiology Films

X History & Physical X Laboratory Reports X Billing Information

X Operative Report X Pathology Reports Other (Must Specify)

Psychiatric Reports X Radiology Reports

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or hum immunodeficiency virus (HIV), behavioral or mental services and treatment for alcohol and/or drug abuse.

Federal law protects the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected.

The provision of treatment may not be conditioned upon the execution of this authorization unless treatment is provided in conjunction with research or if the purpose of the treatment is solely for disclosing information to a third party (i.e. fitness for work or life insurance information).

This authorization will expire upon the occurrence of the following date or condition:

CLAIM SETTLEMENT, ONE YEAR FROM DATE OF SIGNATURE, OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to EMC Risk Services, Inc and the City of West Des Moines Human Resources Department. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. I understand that I will be given a copy of this Authorization form, after signing it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Authorized Representative