

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

**Department of Workforce Development
Worker's Compensation Division**
 201 E. Washington Ave., Rm. C100
 P.O. Box 7901
 Madison, WI 53707
 Imaging Server Fax: (608) 260-2503
 Telephone: (608) 266-1340
 http://www.dwd.wisconsin.gov/wc
 e-mail: DWDDWC@dwd.wisconsin.gov

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
 (Please read the instructions on page 2 for completing this form)

EMPLOYEE	Employee Name (First, Middle, Last)		Social Security Number*		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Employee Home Telephone No.		
	Employee Street Address			City	State	Zip Code	Occupation		
	Birthdate	Date of Hire		County and State Where Accident or Exposure Occurred?					
EMPLOYER	Employer Name AllStaff Payroll, Inc.		WI Unemployment Ins. Acct No.		Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Nature of Business (Specific Product)		
	Employer Mailing Address 2101 North 9th Avenue			City Pensacola	State FL	Zip Code 32503	Employer FEIN 59-3214402		
	Name of Worker's Compensation Insurance Co. or Self-Insured Employer						Insurer FEIN		
	Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer						TPA FEIN		
WAGE INFORMATION	Wage at Time of Injury \$		Specify per hr., wk., mo., yr., etc. Per:		In Addition to Wages, Check Box(es) if Employee Received: <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Tips		No. of Meals/wk. No. of Days/wk. Avg. Weekly Amt. \$		
	Is Worker Paid for Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, After How Many Hours of Work Per Week?								
	For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.								
	No. of Weeks:		Gross Amount Excluding Tips: \$			If Piece-Work, No. of Hrs. Excluding Overtime:			
	Employee's Usual Work Schedule When Injured:			Start Time <input type="checkbox"/> AM <input type="checkbox"/> PM		Hours Per Day	Hours Per Week	Days Per Week	
	Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:								
INJURY INFORMATION	Part-Time Employment Information:		Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many?			Number of Full-Time Employees Doing the Same Type Of Work:			
	Injury Date	Time of Injury AM PM		Last Day Worked	Date Employer Notified	<input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return			
	Did Injury Cause Death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Death		Was This a Lost Time or Other Compensable Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury Occur Because of: <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Failure to Use Safety Devices <input type="checkbox"/> Failure to Obey Rules		
	Was Employee Treated in an Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No Was Employee Hospitalized Overnight as an In-Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No								
	Name and Address of Treating Practitioner and Hospital:								
	Case Number from the OSHA Log:								
Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.									
What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)									
What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)									
Report Prepared By		Work Phone Number		Position		Date Signed			

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

**REPORTING GUIDELINES FOR WORK PLACE INJURIES
(WORKER'S COMPENSATION INSURANCE)
CATHOLIC MUTUAL GROUP**

The State of Wisconsin Worker's Compensation Act provides for payment of reasonable medical expenses and compensation for lost wages resulting from work-related injuries or disabilities. Information regarding this state-mandated insurance program can be found at <https://dwd.wisconsin.gov/wc/workers/>.

- 1) Effective January 1, 2016, Catholic Mutual Group (Catholic Mutual) partnered with Church Mutual Insurance Company (Church Mutual) for the handling of Workers Compensation claims for the Diocese of Madison. Previously PPIC (Preferred Professional Insurance Company) was the carrier. Catholic Mutual Group will continue to work as a third party administrator/advocate in handling claims of employee Injuries for the Diocese of Madison.
- 2) Even in the safest of workplace environments, injuries can happen. If an employee is hurt and the injury is serious or life-threatening, call 911 immediately.
- 3) If an employee experiences a non-life threatening injury on the job, call the Church Mutual Nurse Hotline at 844-322-4662. The Church Mutual Nurse Hotline connects you with a medical professional that can advise you on next steps regarding treatment alternatives.
- 4) A parish should report all work-related injuries or ailments to CMG immediately, even if medical treatment through first aid or a medical clinic is not sought or recommended. Promptly reporting a claim will allow CMG and Church Mutual to conduct a proper investigation to determine compensability.
- 5) Complete the *Employer's First Report of Injury or Disease* soon after the employee reports an injury or accident. Details of the incident are always more accurate when information is fresh in one's mind. Please note that this injury report MUST be signed by an authorized representative of the employer, NOT signed by the employee.
- 6) All completed *Employer's First Report of Injury or Disease* reports must be sent to Kris Twining, Claims/Risk Manager as soon as possible via email to ktwining@catholicmutual.org, or via facsimile to 608-833-3794, or if necessary via U.S. Mail to 702 South High Point Road, Suite 221, Madison, WI 53719.
- 7) Contact Kris Twining immediately at 608-821-4566 immediately if any of the following occur:
 - a. A previously reported medical only claim turns into a lost time claim.
 - b. Any serious injury that results in hospitalization.
 - c. Any incident or accident resulting in a fatality.
 - d. Any incident involving odd or questionable circumstances.
- 8) Once a claim is reported, the following will occur:
 - a. Catholic Mutual will interface with Church Mutual to file the claim. Church Mutual will report injuries to the State of Wisconsin in compliance with state reporting requirements. All *Employers' First Report of Injury or Disease* forms need to be completed in their entirety to expedite state reporting.
 - b. Church Mutual will take a direct approach to claims handling - they will investigate all lost time injuries by making contact with the employer, the injured worker, and the attending physician.
 - c. Any injured worker that has lost time from work is required to provide a written release from the attending physician prior to return to work.

- d. Employers are encouraged to contact the injured worker while recovering at home to show Interest In their recovery and to assure them that they are looking forward to their return to work. An injured worker often needs encouragement to get them back into the work force. Too often we hear "The employer does not care because I have never heard from them."
- e. Catholic Mutual will work closely with Church Mutual's claims professionals in an effort to return the employee to gainful employment as soon as possible. In addition to getting your employees the treatment they need in a timely manner, the Nurse Hotline also helps ensure that if you need to file a claim, you do so in a timely manner, which helps reduce costs and confusion.

Issued: January 21, 2016