

Marathon County Workers' Compensation Injury Or Illness Report Form

Procedures

- ▶ Contact the 27/7 Workers' Comp Nurse Triage Line at **Nurse Triage Line at 844-891-6020** to assess injury or illness and provide care instructions. The employee will also need to complete the this form. For serious injury and/or illness, the employee should seek immediate medical treatment and contact the Nurse Triage Line as soon as possible.
- ▶ In the event of a fatality or very serious accident, immediately contact the Human Resources Department at 715-261-1451 and ask for Sue Fox or Sharon Prasnicky, or contact Molly Adzic, Human Resources Director at 715-261-1406.
- ▶ Employee Responsibility: Complete Section A of the form, within 2 days of the injury or illness, if possible. If the employee is unable to complete it, the supervisor should complete Section A.
- ▶ Supervisor Responsibility: Complete Section B and send the completed form to the Human Resources Department within 2 days of the injury or illness. Also route a copy to the department head, if required. **Email: Countybenefits@marathoncounty.gov**

Section A — Completed By Employee, If Possible

Employee's Name		Job Title	
Department	Time Workday Began	<input type="checkbox"/> AM	<input type="checkbox"/> PM
Date of Injury or Onset of Work-Related Illness	Time of Injury / Illness	<input type="checkbox"/> AM	<input type="checkbox"/> PM
Office Phone #	Home Phone #	Cell Phone #	
Date & Time Reported Injury / Illness to Supervisor	Date	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Supervisor Name	Supervisor's Work Phone #		

If not reported to supervisor on day of injury / illness, why?

Specific location of injury / illness (examples; name of building and the exact location within building, main entrance steps located on the east side of Courthouse; property address, street address, include truck or vehicle #, etc.)

What were you doing just before the injury / illness occurred?

What happened / how did the injury or work-related illness occur?

What is the injury / illness? (Please be specific in your description of the injury / illness and identify the body part affected on the below chart)

Part of body injured (check **ALL** that apply, and check appropriate position) Thumb = Finger 1; Big Toe = Toe 1

Abdomen	Eye R L	Finger – 5 th R L	Hip R L	Pelvis	Toe – 4 th R L
Ankle R L	Elbow R L	Foot R L	Knee R L	Ribs	Toe – 5 th R L
Arm R L	Finger – 1 st R L	Groin	Leg R L	Shoulder R L	Wrist R L
Back - Upper	Finger – 2 nd R L	Hand R L	Mouth	Toe – 1 st R L	
Back – Middle	Finger – 3 rd R L	Head	Neck	Toe – 2 nd R L	
Back - Lower	Finger – 4 th R L	Heel R L	Nose	Toe – 3 rd R L	
Other – Please specify:					
For hand and arm injuries, please check your dominant arm: Right <input type="checkbox"/> Left <input type="checkbox"/>					

Type of Injury / Illness

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Concussion	<input type="checkbox"/> Gun Shot	<input type="checkbox"/> Rash/Dermatitis
<input type="checkbox"/> Amputation	<input type="checkbox"/> Cut/Laceration	<input type="checkbox"/> Infection	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Bite	<input type="checkbox"/> Exposure	<input type="checkbox"/> Numbness	<input type="checkbox"/> Strain / Sprain
<input type="checkbox"/> Bruise / Contusion	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Pain	<input type="checkbox"/> Whiplash
<input type="checkbox"/> Burn	<input type="checkbox"/> Fracture	<input type="checkbox"/> Puncture	
<input type="checkbox"/> Other – Please list:			

What object or substance (tools, machinery, objects, chemicals, etc.) directly harmed you? (Leave blank if this does not apply to the incident)

What protective devices/equipment were utilized or worn:

If operating equipment, machinery, and/or other motorized equipment(s) lead to injury / illness, describe the equipment(s):

Was there any other safety equipment/resource available that could have been used to prevent this injury / illness?

Yes No Unknown

If yes, explain:

If physical handling was involved, describe the object/person being handled/lifted at time of the injury / illness:

Approximate size		Approximate weight	
Description			

Explain the environmental factors (lighting, temperature, noise, vibration, dust or weather), if any, that you feel contributed to this injury / illness?

Were there witnesses?

Yes No Unknown

If yes, witness name(s) and phone #(s):

Did anyone else contribute to this injury / illness?

Yes No Unknown

If yes, please list name(s)

Did injury / illness involve outside third party?

Yes No Unknown

(i.e. car accident, confrontation with inmate, etc.)

If yes, please list name(s) and phone number, if known:

Did you have any lost work time related to this injury / illness?

Yes No Unknown

If yes, please complete:

Last Day Worked	
Date or Estimated Date of Return	

Did or will you seek professional medical treatment?

Yes No Unknown

If yes, provide physician and clinic name(s):

First Aid only?

Yes No

Have you ever been treated for a similar injury (same part of body or condition)?

Yes No Unknown

If yes, when (approximate dates):

Was the equipment being properly used? Yes No Unknown

If no, please explain:

Was there any other equipment/resource available that could have been used to prevent this injury / illness?

Yes No Unknown

If yes, explain:

If physical handling was involved, describe the object/person being handled/lifted at time of the injury / illness:

Approximate size		Approximate weight	
Description			

Explain the environmental factors (lighting, temperature, noise, vibration, dust or weather), if any, that you feel contributed to this injury / illness?

How would this type of injury / illness be prevented from happening again?

Is any follow-up needed? Yes No Unknown

If yes, explain:

What are the specific recommendations you would make in order to prevent this type of accident/injury from recurring?

Would the employee benefit from any type of training? Yes No Unknown

If yes, what type of training?

Action plan to prevent reoccurrence:

Who has been assigned to complete follow-up, if needed?	
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Anticipated completion date	
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Additional Comments:

I certify that the above statements are true and accurate and I understand that a false workers' compensation claim may result in disciplinary action up to and including termination from employment.

Supervisor Signature / Type Name		Date	
Contact Phone #			

**Send Completed Form to Human Resources Department
Email: Countybenefits@marathoncounty.gov
Within 2 Days of Date of Injury & Route Copy to Department Head, If Required.**