

## **“If You Become Injured at Work”**

Follow these steps to ensure your injury is properly reported and treated.

**1. Report the injury to your Supervisor – Promptly! Before the end of the School Day.**

Always tell your supervisor, as soon as possible, even if the injury appears to be minor. Always work with the supervisor to fill out an “Injury Report” and sign the CMRC Release Form

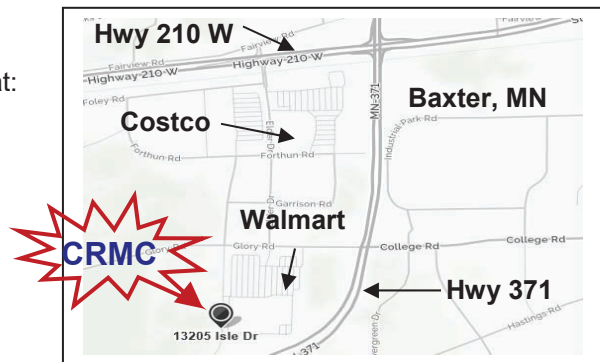
**2. Call Health Partners CareLine at: 952-883-5484 or 888-544-5484.**

Health Partners CareLine will assess your injury and will notify the ISD 181 Work Comp Administrator. The ISD 181 Work Comp Administrator will notify SFM Insurance via the [CompOnline](#) Risk Management System on the day of the injury.

**3. If Medical Attention is needed -**

Have your work-related injury or illness evaluated at:

**Cuyuna Regional Medical Center**  
13205 Isle Drive  
Baxter, Minnesota 56425



Call **CRMC** to Schedule an Appointment: **218-454-7600**

**You MUST call ahead for an appointment. You CANNOT just “show up.”**

**4. Fill Out the Paperwork**

- The Injured Employee will fill out the Injury Report and sign the CMRC Release form.
- Submit the Injury form and CMRC Release form to your building secretary.
- The doctor fills out and provides a Return-To-Work or Workability Report to the injured employee. This form will list your work restrictions. **The School District needs to have this form BEFORE you can Return-To-Work.** It is the School District’s Policy to accommodate work related injury restrictions whenever possible. It is the Employees’ responsibility to work within those restrictions. Return this completed form to the Building Secretary within 24 Hours. The Building Secretary will scan and email the form to Travis Straumann upon receiving it from the employee.

**5. Turn in Your Paperwork**

Every time that you go to the doctor for a work related injury appointment the doctor will give you an updated Return-To-Work Form or Workability Report. Turn this form into your Building Secretary. Your building Administrator will review your work restrictions, if any, and forward a copy to Travis Straumann.

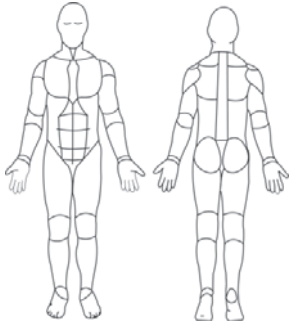
**6. Call If You Have Any Questions**

Workers’ Compensation can be confusing, especially when you are hurt and experiencing pain. If you have any questions or concerns regarding your medical treatment, medical bills, light duty, return-to-work, or payroll, please contact:

Travis Straumann, ISD 181 Workers’ Compensation Administrator at:  
218-454-6907 (Office) or [Travis.Straumann@isd181.org](mailto:Travis.Straumann@isd181.org)

# INJURY REPORT FORM

OSHA Case # \_\_\_\_\_

<b>Date of injury</b>		Your name		Your title	
Employee's last name		First name & middle initial		Employee's Social Security Number	
Home address		City		State & zip code	Phone number
Date of birth		Date hired		Occupation/Department	
Gender  <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital status  <input type="checkbox"/> Married <input type="checkbox"/> Not Married		Employment status  <input type="checkbox"/> FT <input type="checkbox"/> PT	
Location of accident (Be specific)		Time employee started work  am / pm	Time of injury  am / pm	Date employer notified of injury	
Date employer notified of lost time	First date of lost time		Return to work date		
Was employee paid full wages on the date of injury?	Emergency room visit?		Overnight inpatient stay?	Where?	
Describe the nature of the illness or injury. Be specific. Indicate the body parts involved on the diagram to the right.					
Describe the employee's activities when the illness/injury occurred: (detail clearly so the reader can visualize the event)					
WHAT TOOLS, EQUIPMENT, MACHINES, OBJECTS OR SUBSTANCES WERE INVOLVED?					

**PHYSICIAN AND HOSPITAL TREATMENT**

Physician's name: \_\_\_\_\_ Phone#: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Hospital or clinic name: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_

**WITNESS INFORMATION**

Witness name: \_\_\_\_\_ Phone # \_\_\_\_\_

Witness comments:

**ACCIDENT CONDITIONS**

**INDOORS**

**OUTDOORS**

What was the issue?

What was the issue?

**ACCIDENT CAUSES**

Was the wrong tool or piece of equipment used?  Yes  No

Was there an unsafe condition involved with the equipment or tool?  Yes  No

Corrective action required?:  Repair  Replace  Other (*Describe below*)

Comments:

**SURROUNDINGS**

**CORRECTIVE ACTIONS RECOMMENDED**

Poor Lighting?  Yes  No

Poor Access?  Yes  No

Poor Housekeeping?  Yes  No

Poor Visibility?  Yes  No

Vehicle / Eq. Involved?  Yes  No

**PROCEDURE**

Was there a procedure associated with the task at the time of the accident?  Yes  No

If Yes, was it being followed correctly:  Yes  No (If No, explain)

Did the procedure fail to prevent the accident?  Yes  No (If Yes, explain how)

**EMPLOYEE**

Length of employment in years: \_\_\_\_\_ years

New employee?  Yes  No If Yes, number of months employed: \_\_\_\_\_ months

Was employee new to job?  Yes  No (if yes, how long in the job): \_\_\_\_\_

Was employee trained?  Yes  No

Did the accident involve?

Horseplay  Inattention  Poor Judgment  Unauthorized Operation  Student

Explain:

Immediate corrective actions taken.....

**EQUIPMENT**

- Locked-Out
- Repaired
- Replaced
- Discarded
- Other

**SURROUNDINGS**

- Modified
- Cleaned-up
- Posted
- Evacuated
- Other

Additional corrective actions needed?

Yes  No

**SUMMARY OF CORRECTIVE ACTIONS RECOMMENDED AT THIS TIME**

Employee:

Procedure:

Training:

Equipment/tools:

Surroundings:

**ADDITIONAL FACTS / INFORMATION**

Were photographs taken?  Yes. Describe what the photo is of  No

**ACKNOWLEDGEMENTS**

Employee \_\_\_\_\_  
*Signature* *Date*

Supervisor \_\_\_\_\_  
*Signature* *Date*

Date reviewed by Safety Committee \_\_\_\_\_

**Authorization to Release Protected Health Information**

**Crosby, Longville, Baxter, Care Center and Home Health Partnership**  
 Phone: 218-545-4466 Fax 218-546-6091

<b>Patient Information</b>	<b>Name (first &amp; last name)</b>	<b>Date of Birth</b>	<b>Phone Number</b>
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**\*Patient's Email Address:**

**Instructions:** If any section is incomplete, this form may be invalid and could cause a delay in processing.

**Release Information From**

CRMC, 320 East Main Street, Crosby, MN 56441  
 Other (specify facility/individual & address below, including phone / fax if known)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Release Information To**

CRMC, 320 East Main Street, Crosby, MN 56441  
 Other (specify facility/individual & address below, including phone / fax if known) \_Health Partners/Work Comp managed care  
 Mail Stop 21106A  
 PO Box 1369  
 Minneapolis, MN 55440  
 FAX: 952-853-8732

**Purpose for Release**

Continued Care     Work Comp     Personal     Legal Purposes  
 Application of Insurance     Disability Determination     Payment of insurance  
 claim Other (details) \_\_\_\_\_

**Information To Be Released**

**\*\*Required - check all that apply**

**Send all Routine Records**

Provider Notes, Lab, Radiology, Procedures, Test Results.

**Or Send Other Records**

Medication List     History & Physical     Provider Notes     Emergency Report  
 Discharge Summary     Care Center Notes     Rehab Records (PT,OT,SP)     Lab Reports  
 Pathology Reports     EKG's     Operative/Procedure Reports     HIV/Aids Testing  
 Radiology Reports     Radiology Imaging     Billing Information  
 Other (specify contents and dates) \_\_ Workability reports \_\_\_\_\_

\*All information regarding alcohol and/or drug abuse, behavioral health and psychotherapy will be released **unless you restrict** by checking below:

\_\_\_\_\_ Do not release alcohol and/or drug abuse information    \_\_\_\_\_ Do not release behavioral health information  
 \_\_\_\_\_ Do not release Psychotherapy Records

**Dates of Service:**

**From:** \_Date of injury: **To:** \_Present \_\_\_\_\_

Information needed by: (optional)

Records Sent \_\_\_\_\_ (initial)

**\*\* A 2 year medical history will be sent for all Continued Care or Personal Use request, unless shorter time is specified.**

**Release Method / Format**

For Copies:  Paper     MyChart     \*Electronic Delivery (to patient only, complete email address above)  
 Pick up (Photo ID required)    For Imaging / MRI:

**This authorization will expire one year from the date of signing unless I indicate and earlier date or event here:** \_\_\_/\_\_\_/\_\_\_

The authorization may be revoked at any time except to the extent that action has previously been taken. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. Copy is as good as an original.

**I give permission for records created after my signature date to be disclosed.**

Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation.	<b>Patient Signature</b> _____	Signature of Authorized Person _____ Date _____
	<b>Date</b> _____	Print Authorized Person's Name _____ <input type="checkbox"/> *Parent of Minor <input type="checkbox"/> Court appointed guardian/conservator <input type="checkbox"/> Healthcare Agent