Workers' Compensation Instructions for Filing a Claim

Please complete following steps within 24–48 hours of the incident:

Report the incident to your supervisor immediately or,
if a medical emergency, dial 911.

1. For non-emergency situations, call CorVel, the State of Arizona Workers' Compensation, at 800-685-2877 to report the injury to a triage registered nurse. This nurse will:
   - Focus on early intervention and **your** immediate needs;
   - Connect **you** with the appropriate level of care;
   - Schedule a referral for further intervention; and
   - Follow up with **you** the next day to see how you are doing.
2. Work with your supervisor to complete the **Employer's Report of Injury Form** and the **Authorization for Payment Form** required to process a worker's compensation claim. Your supervisor will be asked to complete a **Supervisor's Incident Report.** This will ensure any potentially hazardous condition has been corrected.

   All completed forms (included in this packet) must be faxed to the ASU Office of Human Resources Benefits at 480-993-0007.
3. If medical treatment was sought, the employee must have the treating provider complete a **Release to Return to Work Form** and provide a completed copy to their direct supervisor and fax a copy to Human Resources Benefits at 480-993-0007 prior to returning to work. Failure to provide a return to work release will result in the employee being sent home until a sufficient release is provided.

* Failure to report within those timeframes can result in severe monetary fines, payable by your department. Prompt reporting will accelerate the claim processing and will avoid unnecessary delays or denial of possible benefits, and/or penalties.

FOR EMERGENCIES

Call 911 immediately.

NON-EMERGENCIES

Call CorVel
State of Arizona
Workers' Compensation
800-685-2877

You will be directed
to a triage registered nurse
to further assist in locating
a preferred treating provider.

PRESCRIPTIONS

Fill prescriptions at any pharmacy, but you must supply the pharmacy with the Arizona Risk Management information.

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment.
ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #: ______

RECORDABLE INJURY ______

NON-RECORDABLE INJURY ______

EMPLOYEE

1. LAST NAME | FIRST | M.I.
2. SOCIAL SECURITY NUMBER *
3. BIRTH DATE
4. HOME ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
5. TELEPHONE
6. SEX ☐ MALE ☐ FEMALE
7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER

8. EMPLOYER'S NAME
9. POLICY NUMBER
10. NATURE OF BUSINESS (MANUFACTURING, ETC.)
11. OFFICE ADDRESS (NUMBER & STREET) | CITY | STATE | ZIP CODE
12. TELEPHONE

ACCIDENT

13. DATE OF INJURY OR ILLNESS
14. TIME OF EVENT ☐ A.M. ☐ P.M.
15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M.
16. DATE EMPLOYER NOTIFIED OF INJURY
17. LAST DAY OF WORK AFTER INJURY
18. DATE OF RETURN TO WORK
19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED
20. CLASS CODE ON PAYROLL REPORT
21. EMPLOYEE'S ASSIGNED DEPARTMENT
22. DEPARTMENT NUMBER
23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
24. ADDRESS OR LOCATION OF ACCIDENT | CITY | COUNTY | STATE | ZIP CODE
25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
26. PART OF BODY INJURED
27. FATAL ☐ YES ☐ NO
28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH
29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO

NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO

IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. **WHAT HAPPENED?** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
33. **WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE?** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*
34. **WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED?** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."
35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO
37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M.
38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO
39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE
41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $
42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO
43. NUMBER OF MONTHS EMPLOYMENT AVAILABLE DURING THE YEAR
44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE $ PER ☐ HOUR ☐ DAY ☐ WEEK ☐ MONTH
45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH VALUE $
46. ACTUAL GROSS EARNINGS OF EMPLOYEE FOR THE 30 CALENDAR DAYS PRECEEDING INJURY (EXAMPLE: IF INJURED APRIL 8, GIVE EARNINGS FROM MARCH 9 THRU APRIL 7)
47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IMPORTANT IF EMPLOYEE IS PAID OTHER THAN FIXED WEEKLY OR MONTHLY SALARY, COMPLETE ITEMS 48 THRU 55

48. IF EMPLOYEE EARNS EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAYMENT? PER HOUR
49. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK
50. GROSS WAGES OF EMPLOYEE DURING 12 MONTHS PRECEEDING INJURY FROM THRU $
51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $
52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY
53. WAGE BEFORE INCREASE $
54. WAGE AFTER INCREASE $
55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

AUTHORIZED SIGNATURE

DATE | AUTHORIZED SIGNATURE | TITLE

NOTE TO EMPLOYER:
1. Mail one copy to the Industrial Commission within 10 days.
2. Mail one copy to your insurance carrier within 10 days.
3. Keep one copy, for not less than five (5) years, as your supplementary record of injuries required by the Federal Occupational Safety and Health Act of 1970.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE

Supervisor’s Incident Investigation Report

Office: 480-965-1823 | **FAX:** 480-993-0007

DATE OF INCIDENT: **TIME OF INCIDENT:** ☐ **a.m.** ☐ **p.m.**

EMPLOYEE INFORMATION

Name (Print Last, First, MI):

ASU Employee ID (10 digits): **Job Title:**

INCIDENT INFORMATION – SUPERVISOR TO COMPLETE

Incident Location (campus, building, room no., if applicable):

What PPE was the employee wearing?

Incident Description (i.e., fell from six-ft. ladder, slipped on wet sidewalk, struck head, bumped elbow, chemical in eye, etc.) **and Type of Injury** (i.e., cut, bruise, chemical inhalation, etc.):

What was the employee doing (i.e., installing ballast, walking to building, emptying trash, carrying tools, pouring liquid, etc.)?

Weather conditions:

WITNESSES

1.

2.

MEDICAL

Was the employee given medical treatment? ☐**YES** ☐**NO** ☐**First Aid Only**

Where was the employee treated?

How was the employee transported to treatment?

SUPERVISOR INFORMATION

Name (Print): **Title:**

Department: **Contact No.:**

Corrective Action (i.e., Employee: Coaching, Training; Conditions: Repairs, Removals, etc.):

Supervisor Signature: **Date:**

Employee Signature: **Date:**

EH&S ONLY (Investigative Action)

Industrial Compensation Authorization

TO: STATE RISK MANAGEMENT

I authorize State Risk Management to mail my industrial compensation check(s) for temporary, partial or temporary total disability to the Office of Human Resources' Benefits Office at Arizona State University.

Office of Human Resources
Benefits Design and Management
ATTN: Workers' Compensation
PO Box 871304
Tempe, AZ 85287-1304

I further authorize the Payroll Office at Arizona State University to apply the compensation funds as part of my regular earnings.

________________________________ ____________________
Last Name, First Name, M.I. (Print) Employee ID (10 Digit)

________________________________ ____________________
Employee Signature Date (mm/dd/yy)

FAX THIS FORM TO 480-993-0007

HEALTH CARE PROVIDER RELEASE TO RETURN TO WORK/CERTIFICATE OF ILLNESS

Employee Name: ____

ASU ID (10-digit number):	Date of Illness or Injury (mm/dd/yyyy):	Was this a work-related injury or illness? ☐ Yes ☐ No
☐ The employee may return to full duties WITHOUT restrictions on (mm/dd/yyyy):		

OR

☐ The employee may return to work WITH restrictions as indicated below on (mm/dd/yyyy): ________________________

Is the employee able to return to work full-time? ☐ Yes ☐ No

Is the employee able to return to work part-time? ☐ Yes ☐ No

How many hours can the employee work within a 24-hour period? ____________Hours.

How many days can the employee work within a five-day work week? (Check One) ☐1 ☐ 2 ☐3 ☐ 4 ☐5

Restrictions, If applicable **Check either:** ☐ **Temporary** ☐ **Permanent**			**Duration of Restriction** From (Date)	To (Date)	**Restrictions, If applicable** **Check either:** ☐ **Temporary** ☐ **Permanent**		**Duration of Restriction** From (Date)	To (Date)
Lifting	____ Weight Limitation	☐T ☐P			Maintain Regular Business Hours	☐T ☐P		
Walking	____ Minutes	☐T ☐P			Attend and participate in meetings	☐T ☐P		
Sitting	____ Minutes	☐T ☐P			Concentrating	☐T ☐P		
Standing	____ Minutes	☐T ☐P			Interacting with others	☐T ☐P		
Repetitive Motion	____ Minutes	☐T ☐P			Supervise/instruct staff	☐T ☐P		
If one of the restrictions listed below applies, indicate the employee's limit in the Comments section.					Receive/provide training	☐T ☐P		
	Kneeling	☐T ☐P			Seeing	☐T ☐P		
	Stooping	☐T ☐P			Hearing	☐T ☐P		
	Climbing	☐T ☐P			Other	☐T ☐P		
	Bending	☐T ☐P			**Anticipated date employee can return to full unrestricted duty (mm/dd/yyyy):**			
	Reaching	☐T ☐P						
	Twisting	☐T ☐P						

Comments:

Provider Name:	Signature:
Address:	Date (mm/dd/yyyy):
Telephone:	Fax:

PLEASE GIVE THIS FORM TO EMPLOYEE
EMPLOYEE IS REQUIRED TO PROVIDE THIS INFORMATION TO THE DEPARTMENT