

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 <u>CorVel</u>, 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.
- 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 <u>CorVel</u> 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.

OF I	PLOYER'S REI INDUSTRIAL IN	_	INDUSTRIAL COMMISSION OF ARIZONA P.O. BOX 19070 PHOENIX, ARIZONA 85005-9070					FOR CARRIER USE ONLY					
COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES				MAIL TO: (CARRIER NAME & ADDRESS)				FOR OSHA PURPOSES ONLY					
MUST BE REPORTED WITHIN 24 HOURS.				AIL TO: (CA	RRIER	NAME & AL	DDRESS	5)	OSHA Cas	-			
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.									RECORDABLE INJURY				
ARIZONA REVIS	ED STATUTES 23	-908 & 23-1061	FIR	ST		M.I.			CLIRITY NUMBER 3. BIRTH DATE				
EMPLOYEE	1. EXCENTION E			51			2. 3	SOCIAL SEC	ECURITY NUMBER + 3. BIRTH DATE				
4. HOME ADDRESS (NUMBER & STREET)				CITY STATE				ZIP CODE 5. TELEPHONE					
. SEX		7. MARITAL ST							WIDOWED				
MPLOYER	8. EMPLOYER'S NAM	E			9. POLICY NUMBER				10. NATURE OF BUSINESS (MANUFACTUR			ACTURING, ETC	
1. OFFICE ADDRESS (NUMBER & STREET)			C	CITY STATE				ZIP CODE	CODE 12. TELEPHONE				
	13. DATE OF INJURY	OR ILLNESS	14. TIME OF	14. TIME OF EVENT 15. TIME EMPLOYEE					EGAN WORK				
7. LAST DAY OF WO	RK AFTER INJURY	18. DATE OF R	ETURN TO WORI	K A.IVI	. 🔲 19. EM	PLOYEE'S OCC	UPATION (D			
0. CLASS CODE ON	PAYROLL REPORT	21. EMPLOYEE	'S ASSIGNED DE	PARTMENT	22. DE	PARTMENT NU	MBER	23	23. DID INJURY OCCUR ON EMPLOYER PREMISES?				
4. ADDRESS OR LOO	CATION OF ACCIDENT				CITY			COUNTY	YES		NO STATE		ZIP CODE
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5. WHAT WAS THE I	NJURY OR ILLNESS? Te	ell us the part of the body t	hat was affected a	nd how it was affe	ected; be r	more specific tha	n "hurt," "pa	in," or sore."	' Examples: "str	ained ba	ck"; "chemical bu	rn, hand"; "carpal	tunnel syndrome
6. PART OF BODY IN	JURED		27	. FATAL		^s	NO 28	3. IF THE E	MPLOYEE DIED), WHEN	DID THE DEATH	HOCCUR? DATE	E OF DEATH
9. WAS EMPLOYEE	TREATED IN AN EMERGI	ENCY NAME OF P	HYSICIAN OR OT	HER HEALTH CA	ARE PROP	FESSIONAL			ADDRESS (STR	EET, CIT	Y, STATE & ZIP	CODE)	
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* 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 of 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.



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 – SUPE Incident Location (campus, building, room r					
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					

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

Weather conditions:

and Type of Injury (i.e., cut, bruise, chemical inhalation, etc.):

WITNESSES						
1.	2.					
-						
MEDICAL						
Was the employee given medical treatment?	S ☐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)						



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: ____

			f Illness or Injury (mm/dd/yyyy): W			as this a work-related injury or illness?			
The employee may return to full duties WITHOUT restrictions on (mm/dd/yyyy):									
						OR			
Is the second se	ne employee ab ne employee ab w many hours c	ole to re ole to re an the e	turn to v turn to v employe	work full-time work part-tim ee work within e work within	? e? n a 24-hour a five-day v	☐ Yes [] No] No _Hours.]5
Restrictions If annlicable				Duration of Restriction		Restrictions, If applic	Duration of Restriction		
Restrictions, If applicable Check either:			From (Date)	To (Date)	Check either:	From (Date)	To (Date)		
Lifting	Weight Limitation	□т	□P			Maintain Regular Business Hours	□T □P		
Walking	Minutes	□т	ΠÞ			Attend and participate in meetings	□T □P		
Sitting	Minutes	□т	□Р			Concentrating	□T □P		
Standing	Minutes	П	ΠÞ			Interacting with others	□T □P		
Repetitive Motion	Minutes	□т	□Р			Supervise/instruct staff	f 🗌 T 🔲 P		
If one of the restrictions listed below applies, indicate the employee's limit in the Comments section.					e	Receive/provide trainin	ng 🗌 T 🔲 P		
	Kneeling	□т	□Р			Seeing	□т □р		
	Stooping	□т	ΠÞ			Hearing	□T □P		
	Climbing	□т	ΠÞ			Other	□T □P		
Bending T DP					Antioinated data area	lovoo oon roturr	to full unre-	triated duty	
	Reaching T P					Anticipated date employee can return to full unrestric (mm/dd/yyyy):			tricted duty
Twisting			□Р						

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					