Department of Correction
Workers' Compensation Unit
24 Wolcott Hill Road Wethersfield, CT 06109

To: Injured Employee
From: Workers' Compensation Unit

<u> Important Information Regarding Your New Claim or Recurrence **</u>**

- ✓ Report injury immediately to your supervisor.
- ✓ If you need medical treatment, seek immediate treatment from a Gallagher Bassett Prime provider. Be advised that your claim may not be accepted if you see a physician outside of the Gallagher Bassett Prime provider network. *Network providers website-* http://ct.primehealthservices.com/Search
- ✓ After receiving medical treatment you will receive a Gallagher Bassett Workers' Status report from the physician. **If you are unable to return to work due to your injury you must contact your supervisor and the DOC Workers' Compensation unit immediately.** A copy of the GB Workers' Status report must be submitted to your immediate supervisor and the DOC WC unit.
- ✓ A pharmacy benefit management program is in place to provide prescriptions ordered by the WC treating physician for a work-related injury. Please have your prescription filled by a network pharmacy and ask them to process your prescription through **MyMatrixx. 1-877-804-4900_use BIN#:014211 and RX Group #:10602554**
  http://www.mymatrixx.com/services/pharmacy/pharmacy-locator/
- ✓ Please make sure the following forms have been completed, signed, and dated:
  WC-715 (use of accrual time). You must elect to use or not use accrued leave balances. **If the form is not completed and signed, your accrued time cannot be used, and may result in your pay being docked. Once this form is completed and entered into our system, it Cannot Be Changed. (this form has been revised as of 3-24-10)**
  WCC-1A (Filing Status and Exemption form-This must agree with your IRS filing status for your 1040 Federal Income Tax Return.
  WC-211 (Concurrent Employment and Third Party Liability).

Please be sure to answer all questions on each form completely, sign and date all forms. Payment cannot be made without the completion and signed submission of all the above forms.

- ✓ **Copies of all medical reports and doctors visits should be forwarded to the Workers' Compensation Unit immediately after each visit. Undue delay will have an adverse impact on the timely processing of your workers' compensation benefits.**
- ✓ Extended absence from work must be substantiated by current medical reports, and submitted to both your facility and the DOC workers' compensation unit.
- ✓ **Never sign the WC-207 or 207-1.** These forms are to be completed with your supervisor and only signed by your supervisor
- ✓ Contact your Workers' Comp Liaison **immediately** when your doctor has cleared you to return to work with any type of job restriction and **prior** to your arriving at the facility.
- ✓ If you are released to **full duty**, call your WC liaison, forward copy of your note to her ASAP, call your supv, and return to work on the next scheduled work day with a copy of the full duty release med note.

Incomplete forms will delay processing your claim. On new claims your supervisor, via fax, must forward all forms to the DOC WC unit within 24 hours of your injury.

****If your absence from work is due to a recurrence, you must contact your supervisor and the DOC WC unit immediately. Recurrence claims must be supported by relating medical documentation to be considered for approval by the G B . If your claim is a recurrence, *you* are responsible to fax (860-692-7745) the completed forms (noted above) and the medical note to the DOC WC unit ASAP. Your claim will not be set up until all information is received by DOC WC unit.**

If your claim is 100% and you believe your 75% rate based on your previous 52 weeks of earnings could exceed the 100% rate, please contact your workers comp liaison immediately.

All forms and medicals must be faxed to **860-692-7745** and originals mailed to 24 Wolcott Hill Road, Wethersfield, 06109
All medical documentation and bills must be processed through Gallagher Bassett, 1-866-422-7622.
Workers Comp Liaisons: Kim-692-6896, Mary Lou-692-7853, Sharon-692-7756

Employee______________________________ Date
Supervisor______________________________ Date

Rev 11-07-16

DAS First Report of Injury WC 207

Reference No:

Central Office use only:
Incident No:

Claim No:

The Supervisor must complete this form with the injured worker and then forward it along with the balance of the claim package to the Workers' Compensation Unit within 24 hours.

1. AgencyLocationCode	2. Division/Region		
3.SSN	4.Employee Number	5.Name of Injured Worker *(First) (Last) (MI)*	
6.Home Address (City or Town) (State) (Zip)	7.Home Telephone	8.Date of Birth	9.Sex
10.Job Classification	11. Date of Hire	12.Date of Incident	13.Time of Incident
14.Time Employer Notified	15.Date Employer Notified	16. Was Injury Fatal? YES ☐ NO ☐	17. Date of Fatality

18. How Did the Injury Occur?

19. Type of Injury	20. Body Part(s) Affected	21. Category of Illness or Injury
22. Did Injury Occur on Employer Premises? ☐ YES ☐ NO	23. Location Injury Occured	

24. Injured Worker Seeking Medical Treatment ☐ YES ☐ NO If yes complete question 25	25. Medical Care Provided By: (Physician Name and Address)

26. Were There Any Witnesses to the Injury?
(If yes, give name, address and phone.)

27. To Whom Was Injury Reported? (Name) (Title)

28. SUPERVISOR CONTACT INFO
Please print

Name:
Work Phone:
Best Time to Contact:

I HAVE REVIEWED THE ABOVE FORM FOR COMPLETENESS

29. Signature of Supervisor (or other Designated Authority)

SUPERVISORS REPORT ALL INJURIES - CALL 1-800-828-2717

white agency copy *yellow* agency copy *pink* employee copy

Supervisor's Accident Investigation Report 207-1

The Supervisor must complete this form with the employee and then forward it to the Human Resources office, along with the 207 report, within 24 hours after the incident.

GENERAL INFORMATION

Employee Name	Date of Incident	Location of Incident
Job Title	Time of Incident	Medical Treatment? ☐ ER ☐ First Aid ☐ None ☐ Walk-In ☐ Ambulance ☐ Other
Nature of Injury		

INCIDENT DESCRIPTION: ____________________

____

____

TYPE OF INCIDENT: (check most appropriate, define other if checked)

- ☐ Assault by public
- ☐ Caught in/on/between
- ☐ Shoved by or against an object
- ☐ Contact with heat/cold/chemical
- ☐ Motor Vehicle Accident
- ☐ Slip/Trip/Fall
- ☐ Lifting/Material Handling
- ☐ Foreign body in eye
- ☐ Cumulative trauma
- ☐ Repetitive motion
- ☐ Cut/laceration/puncture
- ☐ Exposure (air quality, etc.)
- ☐ Other

CAUSES/CONTRIBUTING FACTORS *Check all that apply*

CONDITIONS

- ☐ Hazardous process
- ☐ Weather conditions
- ☐ Equipment not available
- ☐ Poor housekeeping
- ☐ Equipment malfunction
- ☐ Ergonomic set-up
- ☐ Floor/ground condition
- ☐ Poor lighting
- ☐ Poor design
- ☐ Carpet/mat
- ☐ Chemicals/cleaning agents
- ☐ Improper PPE
- ☐ Lack of training

BEHAVIORS

- ☐ Failure to follow safety procedure
- ☐ Failure to use PPE
- ☐ Improper technique
- ☐ Using equipment unsafely
- ☐ Inappropriate dress or footwear
- ☐ Failure to obtain assistance
- ☐ Working at unsafe speed
- ☐ Performing task without knowledge/failure to ask
- ☐ Failure to recognize unsafe condition
- ☐ Not in scope of duties
- ☐ Unsafe body mechanics
- ☐ Employee attitude on safety
- ☐ Horseplay
- ☐ Failure to use lookout/tagout
- ☐ Inattention/disfunction
- ☐ Poor judgement responding to unsafe condition
- ☐ Other

ACTION PLAN TO PREVENT RECURRENCE

- ☐ Reinforce employee accountability for safety
- ☐ Monitor work practices
- ☐ Work orders written
- ☐ Maintenance work order written
- ☐ Procedures revised
- ☐ Referrals made
- ☐ Apply OSHA program and manuals
- ☐ Additional training
- ☐ Hepatitus B vaccine
- ☐ Renew bloodborne training
- ☐ Renew hazmat training
- ☐ Ergonomic set-up evaluation
- ☐ Air quality consultation
- ☐ MVA= ☐ Local or ☐ State Investigation
- ☐ Other

MANAGER SIGNATURE:	PRINT NAME:	DATE:
SUPERVISOR SIGNATURE:	PRINT NAME:	DATE:

white copy - Agency pink copy - Agency Human Resources yellow copy - DAS Human Resources

Form 1A

WCC File #____________________

Filing Status and Exemption Form

This form must be executed in every case of Compensable Disability,
For injuries occurring on or after *October 1, 1991*

Name: ____ **SS#**______________________________

Address: ____

In order for the Administrator to determine your weekly benefit rate, as per Public Act 93-228, an Act concerning comprehensive Workers' Compensation reform, it is imperative that you provide us with the following information.

1. There are four (4)-filing statuses provided. You must select one, based upon your **IRS filing status on the date of injury and the filing status you used filing your prior year's Federal and State Tax Returns.**

A. Single ____ B. Head of Household ____ C. Married filing jointly ____ D. Married filing separately ____

2. How many exemptions (include yourself) did you list on your last Federal and State Tax Returns? ________

3. Check all appropriate boxes:

65 years of age or older ☐ legally blind ☐ spouse-65 years of age or older ☐ spouse-legally blind ☐

4. List name (yourself first), date of birth and relationship to you for all exemptions listed on your last Federal and State Tax Returns. (Question #2 above):

Name	Birth Date	Relationship
1.		Self
2.		Spouse
3.		
4.		
5.		
6.		

5. IMPORTANT: To be certain that you receive all the benefits, to which you are entitled, please provide the following information if you were engaged in any other employment at the time of your injury or are currently engaged in any other employment. If you have no other employment, insert the word 'none'…..

Other Employers: Names: ______________________________Addresses: ______________________________

______________________________ ______________________________

Weekly Hours: ____________Weekly wages: $_______________Date of hire: ________________________

Are you currently working: _______________Type of Work Performed: ______________________________

6. This form must be completely filled in. Any person who intentionally misrepresents or fails to disclose any material fact related to a claimed injury may be guilt of a felony.

____ ________________________

Employees Signature **Date**

Concurrent Employment
Third Party Liability Form
Form PER WC-211

State of Connecticut
Department of Administrative Services
Human Resources Business Center

Employee to Complete

Employee Name (Last) (First) (Middle)	Social Security Number
Address (No. and Street	Telephone Number
City or Town	Date of Injury
Employing State Agency: Department of Correction — Location (Facility)	Date of Birth
Address of Facility	Date First Employed by State

Employee Instructions:

The information requested on concurrent employment below is necessary to determine your Workers' Compensation benefit rate

1. You must complete this form for every Workers' Compensation claim you file
2. You must keep the information contained in this form current while you are receiving Workers' Compensation benefits.
3. You must return this form to your personnel office within three days

Note: If your claim is for Temporary Total or Temporary Partial disability benefits, you must advise you employer of any other earnings while receiving these benefits. Failure to do so may result in civil and/or criminal liability.

Concurrent Employment: Check if any of the following apply: ☐ None

☐ Employed by another State Agency ☐ Employed outside State Government

Name of Other Employer	Supervisor's Name	Telephone Number of Employer

Address of Employer (no & Street)	City or Town	State	Zip Code

Third Party Liability Information:

1. Was the cause of you accident/injury the result of the actions of a party other than you or your employer?
   ☐ Yes ☐ No If you checked yes, please describe the facts.

___

Name of Third Party___

Address ___

Insurance carrier of Third Party___

2. Were there any witnesses: ☐ Yes ☐ No
   Name of witnesses___

3. Have you initiated a claim against this responsible Third Party? ☐ Yes ☐ No Date:___

I declare that the above statements are true and correct to the best of my knowledge and I am aware that providing false information may result in civil, or criminal liability.

___ **Employee's Signature** ___ **Date**

Request for Use of Accrued Leave with Workers' Compensation

DAS WC-715

3-10

This form covers an employee election to utilize or not utilize accrued leave (existing balances and additional accruals as credited) during the interim period and/or to supplement lost wage benefits on an approved workers' compensation claim. The Agency Section shall be completed with the initial agency processing of the **LOST TIME** claim and provided to the injured employee with instruction to make an election and ***RETURN WITHIN 10 BUSINESS DAYS***. This form is to be maintained in the injured worker's agency workers' compensation file.

AGENCY SECTION

Agency Name	Department ID

Employee Name	Employee ID

Date of Injury	Daily Pay Rate	**LEAVE BALANCES** As of date of injury Denoted in Hours	Sick	Vacation	Personal	Holiday Comp	Comp

EMPLOYEE ELECTION SECTION - Please check your choice of the options available to you then sign and return to your agency Workers' Compensation office **within ten business days.** Failure to return the completed form to the agency will be administered as an election **not** to utilize accrued leave during the interim period and **not** to supplement the approved workers' compensation lost wage benefit.

USE OF ACCRUED LEAVE FOR INTERIM PERIOD

☐ I elect NOT to use accrued leave during the interim period (after the first day of my incapacity and continuing until such time as a determination of compensation is made).

☐ I elect to use accrued leave during this interim period. By choosing this option I will receive my full base pay while a determination of compensation is being made. I understand that, once a compensation award has been made, I must repay the State an amount equal to the net pay I would have received during such interim period in order for my leave balances to be restored. I further understand that sick leave must be used first, followed by my designated choice of vacation, personal, holiday compensatory time and/or compensatory leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2,3,4,5 in each box:	Sick 1	Vacation	Personal	Holiday Comp	Compensatory

USE OF ACCRUED LEAVE WHILE RECEIVING WORKERS' COMPENSATION

☐ I elect NOT to use any of my accrued leave while I am receiving Workers' Compensation lost wage benefits.

☐ I elect to use accrued leave, which in addition to the lost wage benefits awarded to me under Workers' Compensation, will result in my receiving the equivalent of my full base pay while I am receiving Workers' Compensation lost wage benefits. I further understand that sick leave must be used first, followed by vacation and/or personal leave, as designated below.

Indicate the order in which you wish to use leave balances (if any), upon the exhaustion of your sick leave, by entering the number 2 or 3 in each box:	Sick 1	Vacation	Personal

STATEMENT OF APPLICANT

I have read and understand the above explanation of the choices available to me as a result of my application for workers' compensation. Once made, this election cannot be revoked and will remain in effect until all accrued leave (including any future accruals that may be credited to me) is exhausted or until I return to my pre-injury number of scheduled work hours. **I agree to the conditions applicable to the choices I have checked above.**

SIGNATURE OF EMPLOYEE ____________________ DATE SIGNED

PHYSICIANS WORKERS' STATUS REPORT
For Employees of The State of Connecticut
PER-WC-208 REV. 10/08

State of Connecticut
Department of Administrative Services
Workers' Compensation Division

INSTRUCTIONS

1. To be completed by initial care or attending physician and provided to the injured worker as part of the office visit.
2. Mail or fax copy to State of Connecticut Third Party Claim Administration Company within 24 hours of the office visit.

- GAB Robins North America, Inc., 800 Connecticut Boulevard, East Hartford, Connecticut 06108
  Fax: (860) 291-9875
  Phone: (860) 256-3400

To be Completed By Initial Care Physician or Attending Physician

Employee Name | Social Security Number | State Agency

Division | Facility | Address

Date of Office Visit: _____/_____/_____ Date of Injury: _____/_____/_____ (Circle) Initial Visit ☐ Follow-Up Visit ☐

Diagnosis: ______________________________

Treatment Plan: ______________________________

Evidence of pre-existing condition: Yes ☐ No ☐ Injury/Illness casually related to worker's employment: Yes ☐ No ☐

Patient work disposition (Please check the appropriate work disposition)

1. _____ Patient is capable of full and regular duty.
2. _____ Patient is not capable of any form of work.
3. _____ Patient is capable of modified/restricted work as indicated below

Note: In terms of a normal work day; Occasionally = Up to 33%, Frequently = Up to 66%, and Continuously = Up to 100%

a. Patient is able to:	Never	Occ.	Freq.	Cont.	No Restrictions
Bend	_____		_____	_____	_____
Squat			_____		
Kneel		☐	_____		_____
Stand	_____	_____	_____	_____	_____
Walk	_____		_____	_____	_____
Climb Stairs	_____	_____	_____	_____	_____
Twist	_____	_____	_____	_____	_____
Rotate	_____	_____	_____		_____
Push/Pull	_____	_____	_____	_____	_____
Lift above shoulder		_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____	_____

b. Patient is able to lift	Never	Occ.	Freq.	Cont.	No Restrictions
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____		_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

c. Patient is able to carry	Never	Occ.	Freq.	Cont.	No Restrictions
Up to 10lbs	_____	_____	_____	_____	_____
11-24lbs	_____	_____	_____	_____	_____
25-34lbs	_____	_____	_____	_____	_____
35-50lbs	_____	_____	_____	_____	_____
51-74lbs	_____	_____	_____	_____	_____
75-100lbs	_____	_____	_____	_____	_____

d. Patient is able to use hands	Never	Occ.	Freq.	Cont.	No Restrictions
Keyboard Typing	_____	_____	_____	_____	_____
Grasping	_____	_____	_____	_____	_____

e. Is patient involved with treatment and/or medication that might affect his/her ability to work?

☐ No

☐ Yes: Explanation: ____

f. Will patient be required to use any assistive devices or braces while working regular or modified/restricted duty?

☐ No

☐ Yes: Explanation: ____

Physician Comments: ____

____

____

The restrictions are in effect until: _____/_____/_____ Next appointment Date: _____/_____/_____

Name of Physician: ______________________________ Signature: ______________________________

Please Print

ARRIVED:____________________

DEPARTED:____________________

TRAVEL:____________________

Authorization to Release Information

I hereby authorize this Medical Provider to release my information acquired in the course of my examination or treatment for the above injury to my employer or it's representative.

______________________	______________________	______________________
Patient's Name (Print)	**Patient's Signature**	**Date**