Work Injury / Workers Compensation Packet

At any time you are injured in the course of your employment, you must report the injury as soon as possible. This packet of information includes directions on how to report the injury, the necessary forms for you to complete and some additional information about Workers Compensation.

Filing an Injury/Illness Report

Step 1
Submit a claim by calling Travelers at 800-832-7839. Have your B number ready.

OR

You can complete the Employee First Report of Injury or Illness as soon as possible and return it to the Benefits Division. The form should be returned within 3 days after the injury/illness or as soon as you complete it.

Step 2
Contact Nurse on Call (24x7 Nurse Line for all healthcare needs). Contacting a Nurse on Call is not required but strongly suggested. Please contact the nurse through your healthcare plan:
Dean Nurse 800-576-8773
GHC Nurse 855-661-7350

Step 3
If you seek medical care, ensure your doctor(s) complete the Work Status Report/Medical Services Form at each visit. Return the form to the Benefits Division (FAX: 608-204-0346). Additionally, complete the Medical Authorization Release Form and return it to Travelers (FAX: 877-786-5567) to ensure your medical bills are paid.

What’s Next?
Watch for an email from the Benefits Division and from Travelers with additional information about your injury/illness.

Seeking Medical Treatment
- Generally, you can choose to see any doctor authorized by Workers Compensation.
- Advise your doctor that you have a work-related injury, and tell them you work for the Madison Metropolitan School District. Do not pay for your care yourself or use other health insurance. Be sure to return the Medical Authorization Release Form to Travelers to ensure payment of insurance claims.
- Medical reports are necessary for your injury. Provide your doctor(s) with the Work Status Report/Medical Services Form and have it completed at each doctor appointment and returned to the Benefits Division.
- Nurse on Call services are available to help you if you are injured at work. This confidential and free program allows you to speak to a registered nurse to help you through your injury.

Lost Wages
- You may be entitled to a portion of your lost wages under Workers Compensation law.
- Any work time that is missed in relation to a worker’s compensation claim will be paid through your own available personal time until an approval (compensability) ruling has been given by the workers compensation insurance carrier. If the claim is accepted by the carrier, all time used that has proper documentation will be credited back to you.
- All time away from work, including any related appointments, and/or notice of restrictions must be documented in writing by a licensed physician/medical doctor. Notes from a nurse practitioner (APNP) or physician’s assistant (PA-C) addressing time off or restrictions will not be accepted. All notes must be signed by a licensed physician/medical doctor.
- Postdated notes for lost time will not be accepted and absences may not be paid.
- Please schedule doctor appointments outside of your scheduled work time when feasible.

Returning to Work
- When you are able to return to work, please provide the doctor completed Work Status Report/Medical Services Form to the Benefits Division.
- MMMSD will make a reasonable effort for you to return to work as soon as possible, even with light duty/work restrictions. Restrictions are accommodated even when they are outside your regular scope of work, whenever possible.
- If your doctor releases you back to work and MMMSD is able to accommodate any restrictions and you do not return, any salary/benefits continuation may end.

Contact Information
- MMMSD: Phone: 608-663-1692 / Fax: 608-204-0346
- Travelers: (Workers Compensation Carrier): 800-842-6172 / Fax: 877-786-5567
# IN LIEU OF REPORTING YOUR CLAIM TO TRAVELERS AT 800-832-7839

**Employee First Report of Injury or Illness**

Madison Metropolitan School District  
545 West Dayton Street, Madison, WI 53703

### EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>B Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (city, state, zip)</td>
<td></td>
</tr>
<tr>
<td>Home/Cell Phone</td>
<td>Gender</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Social Security Number (required)</td>
</tr>
</tbody>
</table>

*required*

Employed Elsewhere?  ☐ Yes  ☐ No  If Yes, Where?

### EMPLOYMENT INFORMATION

Date of Hire  
Job Title  
Work Location  
Business Type  
Education  
County  
Dane

### INJURY/ILLNESS INFORMATION

Date of Injury  
Time of Injury  
Specific Location

Describe How the Injury/Illness Occurred

Tools/Objects/Chemicals/Etc Involved in the Injury/Illness  
Body Parts Affected and How Each Was Affected  
Was the injury student induced?

Witness(es) Name(s)  
Witness(es) Phone #

Have You Previously Had Any Problems with the Injury Area(s)?  ☐ Yes  ☐ No  If Yes, Please Describe including Dates:

### MEDICAL TREATMENT INFORMATION

Did you Seek Out of District Medical Treatment?  ☐ Yes  ☐ No  *Call 608-663-1692 if you later decide to seek treatment*

Name of Treating Provider  
Phone Number

Address (city, state, zip)

Were You Treated in an Emergency Room?  ☐ Yes  ☐ No  
Were You Hospitalized Overnight?  ☐ Yes  ☐ No

Are You Missing Time From Work?  ☐ Yes  ☐ No  
First Day Missed  
Estimated Return To Work Date

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**All time away from work (including any related appointments) and Notice of Restrictions must be documented in writing by a licensed Physician/Medical doctor. Notes from a Nurse Practitioner (APNP) or Physician’s Assistant (PA-C) will not be accepted.**

Inform your medical provider that MMSD does have light duty/restrictive work assignments available. Provide the treating physician with a Work Status Report form to complete for documentation of restrictions or lost time.

I attest that the information documented on this form is true and to the best of my knowledge.

Name of Person Completing Form  
Date Completed

Signature

---

MMSD is self-insured for workers compensation  
Insurance Carrier: Travelers, PO Box 3205, Naperville, IL 60566; Fax 877-786-5567
# WORK STATUS REPORT/MEDICAL SERVICE FORM

Fax Immediately to: 608-204-0346 (Custodians please also fax to 608-204-0374)  
Travelers Insurance  
PO Box 3205  
Naperville, IL 60565  
800-832-7839

**EMPLOYER HAS LIGHT DUTY ASSIGNMENTS AVAILABLE**

<table>
<thead>
<tr>
<th>EMPLOYER INFORMATION</th>
</tr>
</thead>
</table>
| Madison Metropolitan School District | Phone: 608-663-1692  
| 545 W Dayton Street, Room 133, Madison, WI 53703 | Fax: 608-204-0346 |

| EMPLOYEE INFORMATION (to be completed by the employee) |  
| Name | Date of Birth |  
| B Number | Social Security Number (required) |  
| Date of Injury | Time of Injury am/pm |  

Employee: To expedite prompt claim handling, this complete form is to be returned to the Madison Metropolitan School District either on the same day of your appointment or, should lost time be incurred, forwarded to the Madison Metropolitan School District the day following your appointment. Be sure to give this form to your supervisor and request that the supervisor forward the paperwork to the Benefits Division.

**MEDICAL INFORMATION (to be completed by the treating licensed physician/medical doctors)**

*EMPLORER HAS LIGHT DUTY ASSIGNMENTS AVAILABLE*

<table>
<thead>
<tr>
<th>Treatment Received At</th>
<th>Clinic</th>
<th>Urgent Care</th>
<th>Emergency Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Exam</td>
<td>Time of Exam</td>
<td>Date of Follow Up</td>
<td></td>
</tr>
<tr>
<td>Diagnosis</td>
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</tbody>
</table>

- Treatment Plan
  - Expected healing time: Days______ Weeks______ Months______ Other ________________
  - Must return for re-evaluation on ______________ (date)
  - To receive PT/OT services at the rate of ______ time per week for ______ weeks
  - Inpatient surgery scheduled for ___________ at ______ am pm
  - Outpatient surgery scheduled for ___________ at ______ am pm
  - No further care required. Discharge as of __________ (date)

- Current Work Status
  - May work full duty as of __________ (date)
  - Presently working as of __________ (date)
  - May not work full or light duty (off of work) until __________ (date)
  - May work light duty now with identified restrictions through __________ (date)
    - Lifting  Pushing  Pulling
      - Maximum Weight in pounds for the above 3 functions: ______ lbs
    - Bending
      - Maximum number of bends per hour: □ 2 □ 6-10 □ 10-20
      - Degree of bend allowable: □ 20-45 □ Full
    - Standing limited to ______ hours per day
    - Sitting limited to ______ hours per day
    - Walking limited to ______ hours per day
    - Keep dressing/wound clean and dry
    - Medication may cause drowsiness. Use caution when operating machinery or equipment.

- Comments:

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Address</td>
<td>Facility Phone Number</td>
</tr>
<tr>
<td>Physician Signature</td>
<td>Date</td>
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</tbody>
</table>
WORKERS COMPENSATION MEDICAL AUTHORIZATION RELEASE FORM

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.

Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

By law, all health care providers must provide to any employee, employer, worker’s compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker’s compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker and have bills paid quicker than if you refuse to authorize the release of medical information.

<table>
<thead>
<tr>
<th>Health Care Provider Name</th>
<th>Street Address</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>P. O. Box</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<table>
<thead>
<tr>
<th>Patient (Employee) Name</th>
<th>Employer Name</th>
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</table>

<table>
<thead>
<tr>
<th>Patient Social Security Number</th>
<th>Patient Birth Date</th>
<th>WC Claim No.</th>
</tr>
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</tbody>
</table>

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient’s health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes all records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker’s compensation claim described above.

**Physical and Other.** Release all records, correspondence, and any other information from whatever source regarding the patient’s physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Physical and Other:

Patient Signature (or Person Authorized to Sign for Patient):  

Date:
In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information, at no charge to me.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker’s compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker’s Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

<table>
<thead>
<tr>
<th>Patient Signature (or Person Authorized to Sign for Patient):</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
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</tbody>
</table>

If not signed by patient, authority/designation to sign is based on the fact that the patient is:

A □ minor □ incompetent □ Disabled □ Deceased □ Other:
SECTION 7
WORKER’S COMPENSATION

7.01 Worker’s Compensation Coverage and Reporting Responsibilities

All employees shall be covered by Worker’s Compensation Insurance.

Any employee who is injured on the job should:

1. Report the injury to the Benefits Division of the Department of Human Resources and his/her supervisor/principal within twenty-four (24) hours after the occurrence of the injury or as soon as practicable by completing and submitting the “Employee First Report of Injury Form” (https://hr.madison.k12.wi.us/jes/hr/wcinjury.docx) and;

2. Seek medical attention, if needed. Injured employees are advised to seek medical treatment as soon as possible after the injury and should have their medical provider(s) complete and submit the “Work Status Report/Medical Services” (https://hr.madison.k12.wi.us/jes/hr/wcstatus.docx) form to the District.

7.02 Benefits While on Worker’s Compensation

If any employee is injured while in the performance of duties for the District, the District shall continue to provide Workers’ Compensation insurance and the employee will be compensated in the following manner:

When an employee is in pay status, the employee shall be paid by the District at one hundred percent (100%) of the salary schedule rate he/she was paid prior to such injury, and the District shall retain all Worker’s Compensation pay received from the carrier on the employee’s behalf. Said pay shall continue for a period not to exceed one hundred and eighty (180) working days for any one (1) such injury or illness. During such period that the employee is receiving pay under the provisions of this Section, he/she shall continue to accrue sick leave credits (if applicable). No employee by reason of this Section shall receive pay for more than fifty-two (52) weeks in any calendar year, provided however, that employee’s shall not be entitled to the provisions of this Section during periods when they are not scheduled to be paid by the District. The employee must provide a physician’s report substantiating the injury and the District’s return to work form must be completed and signed by the physician before the employee returns to work.

Challenge of Workers’ Compensation Claim: If a worker’s compensation claim is contested, the District continues to pay the employee’s full salary during the period of disability up to a maximum of the number of work days following the date of the accident equal to the number of sick leave days then accumulated by such employee. If the contested claim is settled in favor of the employee, the provisions specified in the paragraph above are retroactively applicable and the number of sick leave days consumed is restored to the credit of the employee.

For additional information see: https://board.madison.k12.wi.us/policies/8421
MMSD Policies and Procedures: 8421

Accident Leave

1. If a certified employee of the BOARD becomes entitled to worker's compensation pursuant to Chapter 102 of the Wisconsin Statutes, the BOARD continues to pay the employee's full salary during the period of disability, whether or not such period extends beyond the employee's term of employment, up to a maximum of 180 teaching days; however, such payment of full salary shall be reduced by an amount equal to the amounts paid to the employee as worker's compensation.

2. If a worker's compensation claim is contested, the BOARD continues to pay the employee's full salary during the period of disability up to a maximum of the number of teaching days following the date of the accident equal to the number of sick leave days then accumulated by such employee, providing the employee files a written request for such payment with the BOARD. When the contested claim is settled in favor of the employee, the provisions of the preceding paragraph are retroactively applicable and the number of sick leave days consumed is restored to the credit of the employee.

BOE: 10/4/04