WORKERS’ COMPENSATION FORMS TO BE USED IN THE EVENT OF A CLAIM

THE FOLLOWING FORMS ARE PROVIDED TO ASSIST IN THE FILING OF A WORKERS’ COMPENSATION CLAIM…

- ID Cards - In the event of a Workers’ Compensation loss. Please provide to all supervisors. You can also give this to the injured employee when they are receiving medical attention.

- Physician’s Return-To-Work Recommendations. Must be completed by the doctor before individuals are allowed to return to work. Provide this form along with the ID card above to the injured employee when they are receiving medical attention.

- Accident/Incident Report Form. Every supervisor should have this available and complete it at the time of the loss.

- Employer’s Report of Industrial Injury (Form 101). This must be completed and reported directly to your carrier within 10 days from the notice of accident/injury. Fatalities must be reported within 24 hours. Please forward a copy to us for our records.

- Notification of Transitional Work Assignment. Please personalize this form with your company information as indicated on the top and utilize if transitional work is provided for any injured employee.
**Send this card with the injured employee**

**Insurance Company Contact Information:**
Name: Church Mutual Ins Co  
Policy #: 0318596-07-956280  
Phone #: 800.554.2642 (option 2)  
Fax #: 715.539.4651  
Email: Claims@churchmutual.com

Preferred Provider:  
NextCare Urgent Care  
(Located at Willow Creek & Green Lane)  
2062 Willow Creek Rd, Prescott, AZ 86301  
Phone: 928.443.5103

Insured’s Name: Prescott College, Inc.  
Insured’s WC Contact:  
HR Department: 928-350-4202;  
Email: hr@prescott.edu

**Preferred Provider:**  
NextCare Urgent Care  
(Located at Willow Creek & Green Lane)  
2062 Willow Creek Rd, Prescott, AZ 86301  
Phone: 928.443.5103

Insured’s Name: Prescott College, Inc.  
Insured’s WC Contact:  
HR Department: 928-350-4202;  
Email: hr@prescott.edu

**Workers Compensation Forms to be used in the Event of a Claim**
Supervisors:

Follow these Emergency Procedures:

- Analyze the injury and take appropriate action
  - Provide First Aid
  - Transport by private means
  - Call Emergency Services (911)

- Send this card with the injured employee

- Complete an Incident Report immediately

- Email the Incident Report to:
  HR Department: 928-350-4202;
  Email: hr@prescott.edu

Workers Compensation Forms to be used in the Event of a Claim
## Physician’s Return-To-Work Recommendations

<table>
<thead>
<tr>
<th>Employee’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Of Injury:</td>
<td></td>
</tr>
<tr>
<td>Employer’s Name:</td>
<td>Prescott College, Inc.</td>
</tr>
<tr>
<td>Department and Supervisor:</td>
<td></td>
</tr>
<tr>
<td>Insurance Carrier:</td>
<td>Phone #: 800.554.2642 (option 2) Policy #: 0318596-07-956280 Carrier Name: <em>Church Mutual Ins Co</em></td>
</tr>
</tbody>
</table>

***PLEASE CHECK THE APPROPRIATE BOX OR BOXES BELOW***

- [ ] Employee unable to return to work at this time
- [ ] Estimated return-to-work date:

### JOB DESCRIPTION #1/EMPLOYEE’S REGULAR JOB

- [ ] Employee can return to **regular work** with no limitations on this Date: 
- [ ] Employee can return to regular work **WITH LIMITATIONS** listed below on this date: 

Medical Restrictions Indicated, i.e. Number of Hours, Lifting, Bending, Stooping, Walking, Leave for Related-Medical Appointments, Medications, etc.:

Length of time medical restrictions are expected to last:

### JOB DESCRIPTION #2/TRANSITIONAL WORK

Employee can return to **regular work** with no limitations on this Date: 

Medical restrictions indicated such as: number of hours, medications, leave time for appointments, physical capacities, etc.:

Other Comments:

**Doctor-Please Sign & Date Here:**
ACCIDENT/INCIDENT REPORT FORM

(Complete this form with the information available. DON’T HOLD THE FORM TO OBTAIN ADDITIONAL INFORMATION)

Name of person completing this incident report: __________________________________________________
Phone number of person completing this incident report: _______________________________________

Name of injured person: ______________________________________________________________________

Date of Incident: ____________________ AM / PM  Time of incident: ____________________ AM / PM
Time the employee began work on the date of the incident: ____________________ AM / PM
Date the employer was notified of the incident: __________  Last day of work after the injury: ________
Employee’s occupation (job title) when injured: _________________________________________________
Employee’s assigned department: _____________________________________________________________

Did the injury occur on the employer’s premises? ______ Yes / No
If no, provide the address of the injury occurred: ____________________________________________

Type of injury/illness:

<table>
<thead>
<tr>
<th>Body part affected:</th>
<th>Extent of Injury:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puncture</td>
<td></td>
</tr>
<tr>
<td>Bruise/Contusion</td>
<td></td>
</tr>
<tr>
<td>Laceration</td>
<td></td>
</tr>
<tr>
<td>Fracture</td>
<td></td>
</tr>
<tr>
<td>Irritation</td>
<td></td>
</tr>
<tr>
<td>Heat/Cold Stress</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
</tr>
<tr>
<td>Dislocation</td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
</tr>
<tr>
<td>Insect/Animal Bite</td>
<td></td>
</tr>
<tr>
<td>Amputation</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Abrasion</td>
<td></td>
</tr>
<tr>
<td>Chemical Exposure</td>
<td></td>
</tr>
<tr>
<td>Muscle Strain</td>
<td></td>
</tr>
<tr>
<td>Muscle Sprain</td>
<td></td>
</tr>
<tr>
<td>Burn</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Provide details of the injury: (What happened? Tell us how the injury occurred.)

What object or substance directly harmed the employee?  (Examples: concrete floor; radial arm saw)

What was the employee doing just before the incident occurred?  (Examples: climbing a ladder while carrying material; daily computer key-entry)

Where was the employee treated? ____________________________________________________________

Was the employee treated in an emergency room? ______ Yes / No
Provide the information of the physician or other health care professional:

Name: __________________________  Address: __________________________  Phone: _________________

Was the employee hospitalized overnight as an in-patient? ______ Yes / No
If hospitalized, provide the hospital information:

Name: __________________________  Address: __________________________  Phone: _________________

If another person, not employed by Prescott College caused the accident, provide the name, address, phone and email address of that person:

____________________________________________________________________________________

Witness (Provide name/phone numbers of any witnesses to the injury):

____________________________________________________________________________________

If the validity of the claim is doubted, state the reason:

If no medical attention was desired and/or required obtain signature from injured party...

Signature of injured party __________________________  Date __________________________
(By signing above the injured party acknowledges that he/she did not desire and/or require medical attention.)

* RETURN THIS FORM TO HUMAN RESOURCES IMMEDIATELY AFTER INJURY *

WORKERS COMPENSATION FORMS TO BE USED IN THE EVENT OF A CLAIM
**EMPLOYEE’S REPORT OF INDUSTRIAL INJURY**

**INDUSTRIAL COMMISSION OF ARIZONA**

P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070
Email: webmaster@azic.gov

MAIL TO: “Church Mutual Ins Co”
PO Box 357
Merill, WI 54452

**FOR CARRIER USE ONLY**

**FOR OSHA PURPOSES ONLY**

OSHA Case #: _______________________
RECORDABLE INJURY: _______________________
NON-RECORDABLE INJURY: _______________________

---

**EMPLOYEE**

<table>
<thead>
<tr>
<th>1. LAST NAME</th>
<th>FIRST</th>
<th>M.I.</th>
<th>2. SOCIAL SECURITY NUMBER</th>
<th>3. BIRTH DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HOME ADDRESS**

<table>
<thead>
<tr>
<th>NUMBER &amp; STREET</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>4. TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYER**

<table>
<thead>
<tr>
<th>8. EMPLOYER’S NAME</th>
<th>9. POLICY NUMBER</th>
<th>10. NATURE OF BUSINESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescott Coll, Inc.</td>
<td>0318596-07-956280</td>
<td>Liberal Arts College</td>
</tr>
</tbody>
</table>

**ACCIDENT**

<table>
<thead>
<tr>
<th>13. DATE OF INJURY</th>
<th>14. TIME OF EVENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CAUSE OF ACCIDENT**

<table>
<thead>
<tr>
<th>32. WHAT HAPPENED?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYEE’S WAGE DATA**

**IMPORTANT**

<table>
<thead>
<tr>
<th>36. WAS WORKER IN YOUR EMPLOY WHEN INJURED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>37. HOURS PER DAY WORKED</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.M.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38. WAS EMPLOYEE PAID FOR DAY OF INJURY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. NUMBER OF DAYS PER WEEK COMPANY</th>
</tr>
</thead>
</table>

**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.

**FORM ICA 04-0101 (Rev. 1/01)**

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

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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 23-908 & 23-1061 of Arizona Revised Statutes.*
Date:

Employee’s Name
Address
City, State, Zip

RE: Notice of Employment under the Return-to-Work Program

Dear Employee:

* has a Transitional Work Assignment available for you until your physician releases you to a full work status in accordance with our Return-to-Work Program. Our #1 goal is for you to return to work as quickly and safely as possible.

Your transitional work assignment will last until you return to your regular work assignment or until the company no longer needs you in this position. The position is in this department: ______________ where you will perform modified duties in relation to what your physician, Dr. ________________________, has dictated your physical abilities are at this time. Attached is a copy of his/her release.

We agree to follow the advice of your physician until you are released to full duty.

Your work schedule will be _________ on these days per week ______________ and you will be expected to report to this location _______________ to this supervisor ________________. Your rate of pay will be $________ per ______ (hour, week, or month).

If you do not accept this offer, our company or our insurance carrier may make an adjustment in your compensation benefits based on the earnings this transitional assignment would provide.

We look forward to seeing you on this date: __________. If you have any questions, please call me at ________.

Sincerely,

Loss Control Coordinator/HR Director

cc: Supervisor; Claims Adjuster; Industrial Commission of Arizona

This Section must be completed by the Employee:

I have read and understand the above information. □ I accept this job. □ I decline this position

____________________________________    ____________________
Employee Signature is required               Date is required