TRIBAL FIRST

In case of a work-related injury, send Physician's Initial Report form to:

Tribal First
4160 6th Avenue SE, Suite 207
Lacey, WA 98503
1 877 777 8039

This is not an authorization to treat.
Please call for additional information.

Tulalip Occupational Safety & Health Administration

How To Process Your Workers' Compensation Insurance Claim

The following are steps needed to insure your claim is processed in a timely manner:

1. Immediately report you injury to your supervisor and pick up an Injury Packet from the Health & Safety Department: Dean Henry – 360-716-4439

2. Seek medical attention:

   IMPORTANT: Your employer/Tribal First reserves the right to direct your care to a provided of their choice. Please check with your employer, before seeking medical attention, to verify or not a provider has already been selected.

3. Have the attending physician complete the Physicians Initial Report included in this packet. You may leave this form with your Physician, and he/she will forward it to the insurance company listed on the form. Your attending physician should also complete the Returned to Work Authorization form. This form needs to be returned to the Health & Safety Department to be forwarded to Tribal First with your Accident Report.

4. Complete the upper portion of the Accident Report included in this packet. This should be completed within two days of the injury. **Returned the completed form to the Health & Safety Department.** The Health & Safety Department will complete the bottom portion of the accident report and forward to Tribal First.

5. As soon as Tribal First receives your completed accident report, your claim will be processed and a claim number assigned. **If Tribal First does not receive a completed form, time loss or medical benefits cannot be provided.**

If you have any questions regarding the completion of this packet, please contact the Health & Safety Department (360) 716-4439. You may contact the claims examiner for additional information at Tribal First at 1-877-777-8039

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3. Have the attending physician complete the Physicians Initial Report included in this packet. You may leave this form with your physician, and he/she will forward it to the insurance company listed on the form. Your attending physician should also complete the Return to Work Authorization form. This form needs to be returned to the Health & Safety Department to be forwarded to Tribal First with your Accident Report.

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Injury Reporting Procedures

- In order to avoid delay in the processing of workers compensation benefits the employee should immediately report the injury to their supervisor.

- The supervisor should interview the employee about how their injury occurred and complete an internal incident report. The internal incident report should be given to Human Resources the same day.

- The supervisor should provide the employee with a Claim Packet and instruct the employee to return the packet to Human Resources within 3 days in order to avoid a delay in the processing of their benefits.

- The employee must complete the "worker section" of the ***Accident Report*** form prior to going to the doctor. In emergency situations this form must be completed as soon as the employee is able to do so.

- The accident report must be completed fully and provide a detailed description of how the injury occurred. If the Accident Report is not completed fully or the information being provided is unclear, there will be a delay in workers compensation benefits.

- The employee will be required to take a ***Return to Work Authorization/Disability Certificate*** form to the doctor (the form will have to be signed by a licensed Medical Doctor, or qualified physician) for completion. This form must be returned to the Supervisor or Human Resources the same day. Failure to return the form will affect their worker's compensation benefits. A copy of this form must be sent to Tribal First for consideration of benefits.

- The employee will also be required to take the ***Physician's Initial Report*** to their first treating physician for completion. This form must be completed immediately and sent to Tribal First.

- The employee should have weekly contact with the Supervisor or Human Resources staff to provide reports on their progress.

- An employee may not take Sick, Annual, or Personal Leave while claiming time loss benefits under the worker's compensation claim. If the employee is off work as a result of the injury he/she should be put on a leave of absence without pay from the employer.

- An employee may not return to work without prior authorization from the physician, a completed ***Return to Work Authorization/Disability Certificate*** form signed and dated by the physician will be required.

- An employee who is offered a temporary modified work position to accommodate physical restrictions as a result of the injury will be required to accept the position. Failure to accept the position will result in termination of time loss compensation benefits.

- An employee who is returning to light duty assignment at a lower salary rate or reduced hours may be eligible for partial compensation for the salary difference under their worker's compensation claim.

Please note that it is the employee's responsibility to provide the requested and needed information throughout the claim process. This is especially important if one is off work and receiving time loss compensation benefits. The employee will have to provide to Human Resources and Tribal First the appropriate certification from a qualified physician before time loss benefits can be paid. If the employee submits medical information to you, please forward a copy to Tribal First via fax or mail.

Please notify Tribal First if an employee is off work as a result of the work related injury, is offered light duty employment, returns to work, or refuses to return to work.

CONTACT INFORMATION:

Ward / Tribal First
4313 6th Avenue SE, Suite A
Lacey, WA 98503
Toll Free: 1-877-777-8039
Fax #: 360-413-9291

Injury/Illness Management Checklist

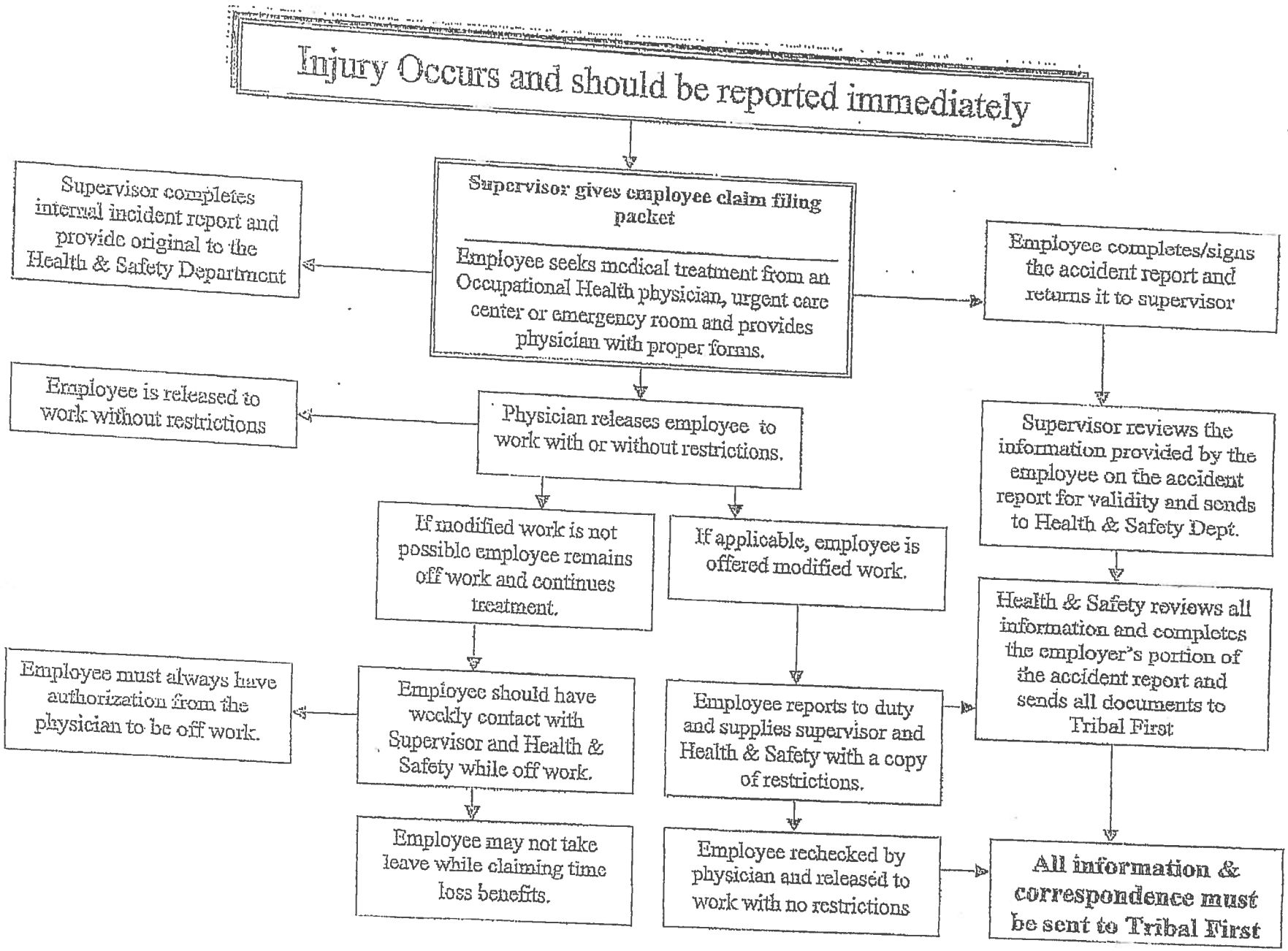
Employee Name:_____ Date of Injury/Illness:_____

Employee's Home Phone #: _____

WHEN AN EMPLOYEE HAS REPORTED AN INJURY/ILLNESS THAT REQUIRES MEDICAL ATTENTION, THE FOLLOWING ACTIONS SHOULD BE TAKEN:

ACTION TO BE TAKEN	DATE COMPLETED
1. Complete internal incident report	
2. Tribal First Claim Packet given to employee	
3. Accident Report and supporting documentation submitted to Tribal First	
4. Obtain employee's work restrictions and identify modified job availability	
5. Meet with the employee to discuss light/modified return to work	
6. Contact Tribal First with return-to-work information	
7. Employee released to full duty or date of employment termination (specify which)	

A copy of all information pertaining to the on-the-job injury must be forwarded to Tribal First as soon as possible.


Injury Occurs and should be reported immediately
Supervisor gives employee claim filing packet
Employee seeks medical treatment from an Occupational Health physician, urgent care center or emergency room and provides physician with proper forms.
Supervisor completes internal incident report and provide original to the Health & Safety Department
Employee completes/signs the accident report and returns it to supervisor
Physician releases employee to work with or without restrictions.
Employee is released to work without restrictions
Supervisor reviews the information provided by the employee on the accident report for validity and sends to Health & Safety Dept.
If modified work is not possible employee remains off work and continues treatment.
If applicable, employee is offered modified work.
Health & Safety reviews all information and completes the employer's portion of the accident report and sends all documents to Tribal First
Employee must always have authorization from the physician to be off work.
Employee should have weekly contact with Supervisor and Health & Safety while off work.
Employee reports to duty and supplies supervisor and Health & Safety with a copy of restrictions.
Employee may not take leave while claiming time loss benefits.
Employee rechecked by physician and released to work with no restrictions
All information & correspondence must be sent to Tribal First

Employer's Report of Occupational Injury or Illness
Instructions for Completing the Form

EMPLOYER SECTION:
Employer should complete Boxes 1 – 4

*The last column on the right side of the form should not be completed. The column is entitled "DO NOT USE THIS COLUMN". This should be left blank.

EMPLOYEE SECTION:
Employee should complete Boxes 5 – 11
Employer should complete Boxes 12 – 13 but if the employee completes this instead the form will still be accepted.
Employee should complete Boxes 14 – 15 and MUST sign the Medical Release, Sovereign Immunity Notice, and False Statement Notice under Box 15.

INJURY OR ILLNESS SECTION:
Employee should complete Boxes 17 – 24
Employer should complete Boxes 25 – 28 but if the employee completes this instead the form will still be accepted.
Employee should complete Boxes 29 – 37

At the bottom of the form there is a section for Employer comments/concerns, Employer Signature, Title & Date. The form must be signed by an authorized representative before submission. If it is unsigned, or signed by an individual not on file, the form will be sent back to the authorized representative on file for signature prior to the claim being set up. Prior to signing the form, you will want to review the following:

- **It is important that the last date worked and return to work information is accurate. If the employee is still off work, please make sure that Box 24 is marked. How the claim will be reviewed for benefits is dependent upon this information.**

- **If the Employee does not complete Box 14 and/or fails to sign the Medical Release, Sovereign Immunity Notice, and False Statement Notice under Box 15, processing of the claim will be delayed.**

- **If the Employee completes all sections of the form, Boxes 1 – 37, please verify the information provided in Boxes 12 – 13 and 25-28 are accurate.**

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

TRIBAL FIRST
4160 6th Avenue S.E. Suite 207
Lacey, Washington 98503
Phone (877) 777-8039 Fax (360) 413-9291

☐ Fatality

EMPLOYER

1. FIRM NAME: **Tulalip Tribes** **ATTN: Dean Henry**
1A. POLICY NUMBER: N/A
DO NOT USE THIS COLUMN
2. MAILING ADDRESS (Number and Street, city, Zip): **6405 Marine Drive Tulalip , WA 98271**
2A. PHONE NUMBER: **(360) 716-4439**
Case No.
3. LOCATION, IF DIFFERENT FROM MAILING ADDRESS (Number and Street, city, Zip)
3A. LOCATION CODE
Ownership
4. NATURE OF BUSINESS, e.g., painting contractor, wholesale grocer, sawmill, hotel, etc.
Occupation

EMPLOYEE

5. EMPLOYEE NAME
6. SOCIAL SECURITY NUMBER
7. DATE OF BIRTH (mm dd yy) / /
Age
8. HOME ADDRESS (Number and Street, city, Zip)
8A. PHONE NUMBER
Daily Hours
9. SEX ☐ MALE ☐ FEMALE
10. OCCUPATION (Regular job title - NO initials, abbreviations or numbers)
11. DATE OF HIRE / /
Days per week
12. EMPLOYEE USUALLY WORKS ____ hours per day ____ days per week ____ total weekly hours
12A. EMPLOYMENT STATUS (CHECK APPLICABLE STATUS AT TIME OF INJURY) regular full time part time temporary seasonal
12B. DEPARTMENT CODE
Weekly hours
13. GROSS WAGES SALARY $ ____ per
13A. OTHER PAYMENTS NOT REPORTED AS WAGES/SALARY (e.g., tips, meals, lodging, overtime, bonuses, etc.)? ☐ YES, $ ____ per ☐ NO
14. Have you ever injured or received treatment to the same body part? ☐ YES ☐ NO
15. Do you have more than one paying job? ☐ YES ☐ NO
15A. Married? ☐ YES ☐ NO
15B. Dependents? ☐ YES ☐ NO

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me.
NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.
16. Employee Signature ____ Date: ____

INJURY OR ILLNESS

17. DATE OF INJURY OR ONSET ILLNESS (mm dd yy) / /
18. TIME INJURY/ILLNESS OCCURRED A.M. P.M.
19. TIME EMPLOYEE BEGAN WORK A.M. P.M.
20. IF EMPLOYEE DIED, DATE OF DEATH (mm dd yy) / /
Weekly wage
21. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ YES ☐ NO
22. DATE LAST WORKED (mm dd yy) / /
23. DATE RETURNED TO WORK (mm dd yy) / /
24. IF STILL OFF WORK, CHECK THIS BOX ☐
County
25. PAID FULL WAGES FORTHE DAY OF INJUY OR LAST DAY WORKED? ☐ YES ☐ NO
26. SALARY BEING CONTINUED? ☐ YES ☐ NO
27. DATE OF EMPLOYER'S KNOWLEDGE/ NOTICE OF INJURY/ILLNESS (mm dd yy) / /
28. DATE EMPLOYEE WAS PROVIDED EMPLOYEE CLAIM FORM (mm dd yy) / /
Nature of injury
29. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS, if available, e.g., second degree burn on right arm, tendonitis of left elbow, lead poisoning.
Part of body
30. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City)
30A. COUNTY
30B. ON EMPLOYER'S PREMISES? ☐ YES ☐ NO
Source
31. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g., shipping department, machine shop.
32. OTHER WORKERS INJURED/ILL IN THIS EVENT? ☐ YES ☐ NO
Event
33. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g., acetylene, welding torch, farm tractor, scaffold.
Sec. Source
34. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g., welding seams of metal form, loading boxes onto truck
Extent of injury
35. HOW INJURY/ILLNESS OCCURRED, DESCRIBED SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURY/ILLNESS, e.g., worker stepped back to inspect work and slipped on scrap metal. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY.
36. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, Zip)
36A. PHONE NUMBER
37. IF HOSPITALIZED AS AN INPATIENT, NAME AND ADDRESS OR HOSPITAL (Number and Street, City, Zip)
37A. PHONE NUMBER

Employer comments/ concerns

Completed by (type or print)	Signature	Title	Date
Dean Henry			

FILING THIS REPORT IS NOT AN ADMISSION OF LIABILITY

MAIL TO TRIBAL FIRST

TRIBAL FIRST

PHYSICIAN'S INITIAL REPORT

1. NAME OF EMPLOYER
Tulalip Tribes of Washington ATTN: Dean Henry

ADDRESS
6405 Marine Dr.

CITY: Tulalip | STATE: WA | ZIP: 98271

NAME OF EMPLOYER'S SERVICE REPRESENTATIVE

Tribal First
4160 6th Ave SE, Suite 207
Lacey, WA 98503

EMPLOYER'S TELEPHONE NUMBER: (360) 716-4439

EMPLOYER'S SERVICE REP PHONE: 1-877-777-8039

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST

3. WORKER'S TELEPHONE #

4. MAILING ADDRESS

5. SOCIAL SECURITY NUMBER

6. CITY | 7. STATE | 8. ZIP | 9. DATE OF BIRTH (MM/DD/YY)

10. INJURY DATE | 11. TIME ☐ AM ☐ PM | 12. Have you missed work due to your injury? If so, what dates were you off? From: To:

13. SEX | 14A. MARITAL STATUS | 14B. NUMBER OF DEPENDENTS

15. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider- START HERE

22. Date patient first seen by you for this injury/condition:

a. ICD DX CODES	b. Diagnosis - specify Right/Left

23. Are there objective findings to support this diagnosis
☐No ☐Yes, Specify

24. Referred for Diagnostic Studies
☐No ☐Yes, Specify

25. Treatment Recommendations:

26. Referred Healthcare Provider (Patient Referred for Follow-Up)

Address:

Phone:

16. MEDICAL RELEASE AUTHORIZATION:
I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE ANY RELEVANT MEDICAL RECORDS OR OTHERINFORMATION REGARDING TREATMENT PREVIOUSLY FURNISHED TO ME.

Worker's Signature Date:

17. NOTICE: Making any knowingly false or fraudulent statement or withholding information is unlawful.

Worker's Signature: Date:

18. a. Has the worker ever been treated for the same or similar condition?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

b. Is there any pre-existing impairment of the injured area?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

c. Are there any conditions that will prevent or retard recovery?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

d. Was the diagnosed condition caused by this injury or exposure on a more probable than not basis?
No ☐ Yes ☐

19. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?
Lifting _____
Bending _____
Standing _____
Sitting _____
Other _____

d. If not released, how many days off work due to the work injury?

20. Licensed Healthcare Provider must sign before report is accepted

Signature: Date:

Phone:

21. Attending Healthcare Provider Name:

Address:

City: State: ZIP:

15. IRS Account #

DO NOT SEND THIS FORM TO LABOR & INDUSTRIES

Tribal First
4160 6th Avenue SE, Suite 207
Lacey, WA 98503
FAX: 360-413-9291

ACTIVITY PRESCRIPTION FORM (APF)

General Info

Worker's Name:	Visit Date:	Claim Number:
Healthcare Provider's Name (printed):	Date of Injury:	Diagnosis:

Required: Released for work? *Check at least one*

☐ Worker is released to the job of injury without restrictions on (date): ____/____/____ *Skip to "Plans" section below.*

☐ Worker may perform modified duty, if available, from (date):
____/____/____ to ____/____/____

☐
____/____/____ to ____/____/____

☐ Worker *is* working modified duty or limited hours
Please estimate capacities below and provide key objective findings at right

☐ Worker not released to any work from (date): ___/___/___ to ___/___/___

☐ Prognosis poor for return to work at the job of injury at any date

☐ May need assistance returning to work
Capacities apply 24/7, please estimate capacities below and provide key objective findings at right.

Required: Key Objective Finding(s)

Required: Estimate what the worker can do *Unless released to JOI*

Capacity duration (estimate days): ☐ 1-10 ☐ 11-20 ☐ 21-30 ☐ 30+ ☐ permanent

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	50 lbs	20 lbs	10 lbs	0-10 lbs	0 lbs
Lift L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs
Carry L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs
Push / Pull L, R, B	___ lbs	___ lbs	___ lbs	___ lbs	___ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: ____/____/____
Name of contact:_____
Notes:

Note to Claim Manager:

New diagnosis:_____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected. ☐ Slower than expected. *Address in chart notes*

Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other_____

Surgery: ☐ Not Indicated ☐Possible ☐ Planned
Comments:

☐ Next scheduled visit in: _____ days, _____weeks.
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐Yes ☐No ☐Possibly
If you are qualified, please rate impairment for your patient.
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to:_____
☐ Consultation needed with:_____
☐ Study pending:_____

Sign

Signature (**Required**): _____ ( )___-_____ Date: ____/____/____
☐ Doctor ☐ ARNP ☐ PA-C Phone number

☐ Copy of APF given to worker ☐ Discussed with worker

TRIBAL
FIRST
INSURING NATIVE AMERICA

Date: _____
Injured Worker Name: _____
Claim Number: _____

RETURN TO WORK AUTHORIZATION
DISABILITY CERTIFICATE

____ The injured worker is medically and physically able to perform work without restrictions effective _____.

____ The injured worker is released for light duty/modified work with the following restrictions: _____

_____

_____

Anticipated duration of disability is _____

Please provide the objective medical findings to support disability. ***This is required***: _____

_____

_____

____ The injured worker is not released to any type of work based on the following: Please provide the objective medical findings to support disability. ***This is required***: _____

_____

_____

Anticipated duration of disability is _____

The injured worker requires further treatment ____ Yes ____ No
Diagnosis of all work related conditions are: _____

_____

Next appointment date _____

Comments: _____

_____

_____

_____

Physician Signature Print Name

_____

Date: Phone Number

"TOSHA"
~Tulalip Occupational Safety & Health Administration~

EMPLOYEE ACCIDENT REPORT

(To be filed out for all job related accidents)

Employee Name:_____ SS#:_____
Office #:_____ Cell#:_____ Home #:_____
Job Title:_____ Dept:_____
Date of Accident:_____ Time of Accident:_____ A.M./P.M.
Location of Accident:_____
Name of Person you first reported accident to:_____ Time:_____
Supervisors Name:_____ Dept:_____
Name of Witnesses (if any):_____
Describe how the accident occurred in detail:

_____
_____
_____
_____
_____

Weather Conditions (if applicable):_____
Was anyone else involved in the accident?_____ If so, Who?_____
If you were injured, please explain your injury in detail:_____
_____
_____

Is this an original injury or re-injury?_____ If re-injury, date of original injury:_____
Was first aid administered?_____ If so, what type?:_____
Date you sought Medical Attention:_____ Doctor's Name:_____
Office/Hospital:_____ Type of Treatment required:_____

Did you miss any time from work?_____ If so, Dates & Time:_____
Date you will be able to return to work?_____
What is your current hourly rate of pay?:_____
What do you think could be done to avoid this accident from occurring again?:_____
_____
_____

RETURN THIS ACCIDENT REPORT TO TOSHA ASAP!!! REMEMBER, IF THIS WAS AN INJURY ACCIDENT, YOU WILL BE REQUIRED TO HAVE A RETURN TO WORK RELEASE FROM THE PHYSICIAN.

Signature:_____ Date:_____

TOSHA:_____ Date:_____

"TOSHA"
~Tulalip Occupational Safety & Health Administration~

SUPERVISOR'S REPORT OF AN ACCIDENT

Employee Name:_____ Dept:_____
Supervisor's Name:_____ Phone#:_____
Job Title:_____ Dept:_____
Date of Accident:_____ Time of Accident:_____ A.M./P.M.
Location of Accident:_____
Name of Person you first reported accident to:_____ Time:_____
Supervisors Name:_____ Dept:_____
Name of Witnesses (if any):_____
Describe how the accident occurred in detail:
_____
_____
_____
_____
_____

Weather Conditions (if applicable):_____
Was anyone else involved in the accident?_____ If so, Who?_____
If you were injured, please explain your injury in detail:_____
_____
_____

Is this an original injury or re-injury?_____ If re-injury, date of original injury:_____
Was first aid administered?_____ If so, what type?:_____
Date you sought Medical Attention:_____ Doctor's Name:_____
Office/Hospital:_____ Type of Treatment required:_____

Did you miss any time from work?_____ If so, Dates & Time:_____
Date you will be able to return to work?_____
What is your current hourly rate of pay?:_____
What do you think could be done to avoid this accident from occurring again?:_____
_____
_____

RETURN THIS ACCIDENT REPORT TO TOSHA ASAP!!! REMEMBER, IF THIS WAS AN INJURY ACCIDENT, YOU WILL BE REQUIRED TO HAVE A RETURN TO WORK RELEASE FROM THE PHYSICIAN.

Signature:_____ Date:_____

TOSHA:_____ Date:_____

"TOSHA"
~Tulalip Occupational Safety & Health Administration~

WITNESS REPORT OF ACCIDENT

Injured Employee's Name:_____ Dept:_____

Name of Witness:_____ Dept:_____
Office #:_____ Cell #:_____

Date of Accident:_____ Time:_____

Did you report this accident to anyone?:_____ If so, Who?:_____
Date:_____ Time:_____

Location of Accident?:_____
Describe how the accident occurred?:_____
_____
_____
_____
_____
Weather Conditions (if applicable)_____
Do you normally work with this person?:_____
Was anyone else injured?:_____ If so, Who?:_____
Were you directly involved in this accident?:_____
What could have been done to avoid this accident?:_____
_____
_____
_____
Any further comments?:_____
_____

Witness's Signature:_____ Date:_____

TOSHA:_____ Date:_____

Time Loss Compensation Benefits

- Time loss compensation is never payable for the date of injury.
- Time loss compensation is not payable for the first three (3) calendar days preceding the date of injury. If fourteen (14) consecutive days are missed from work then the first three (3) days may be payable.
- Time loss compensation is not payable you were kept on salary or have received leave from your Employer.
- Time loss compensation is not payable if you have been released to work with restrictions and your Employer has work in a light duty capacity available for you. If you return to work light duty at a lesser wage, you may be eligible for compensation of up to 80% of the difference between your normal wage and current wage under your workers compensation claim.
- Time loss compensation is not payable if there is not acceptable certification from your physician.
- Time loss compensation benefits are paid at a percentage your gross average wage:

Single w/ 0 Dependents = 60%
Single w/ 1 Dependent = 62%
Single w/ 2 Dependents = 64%
Single w/ 3 Dependents = 66%
Up to a maximum of 75 % Gross Wages

Married w/ 0 Dependents = 65%
Married w/ 1 Dependent = 67%
Married w/ 2 Dependents = 69%
Married w/ 3 Dependents = 71%
Up to a maximum of 75 % Gross Wages

Time Loss Compensation Benefit Calculation:

$_____ ÷ _____ = $_____
Wage History Total # of Months Average Monthly Wage

x Entitlement _____ % = $_____ ÷ 30 Days = $_____
Daily Rate