DIRECTIONS FOR REPORT OF INJURY OR ILLNESS

*****Both pages 1 &2 need to be returned to Human Resources by the end of the shift or within 24 hours of the incident. *****

Page 1 – This page should be filled out by the employee or employee supervisor with knowledge of the incident, should the employee be unable to fill out the form.

- Be as thorough as possible make sure to clearly state the injury.
- Make sure that you are clear as to how the injury occurred.
- Make sure that both the employee and the supervisor sign the form.

Page 2 – this is to be completed by the employee.

*****Pages 3-7 should go with the employee to see their medical provider should they elect to see one.*****

Page 3 – This is a brief overview of Title 21 Employers Liability and Worker Compensation

Page 4– This page will be provided to the medical provider, if seeking medical attention.

- The City of Barre has designated CVMC express care on the Barre Montpelier road as their designated medical provider. They are located next to the Steak House restaurant.
- If you go to the ER you will need to follow up with CVMC Express Care as soon as possible.

Pages 5 &6 – Should you be prescribed a prescription, you can take this form into the pharmacy and fill the prescription.

Page 7 – City of Barre Work Capabilities form

- This needs to be completed by the medical professional and returned to your supervisor prior to returning to work.
- This form has to be completely filled out, by the provider.
- If there are questions not answered you may be asked to return to the medical provider for clarification.
- Answers that are vague: for example (unknown time frame for Return to Work, unknown limitations etc.) May cause a delay in coming back to work. You may also be asked to return to the provider for clarification.
- The City of Barre has a policy on Transitional Return to Work (*Formerly Light Duty*).
- If you are out for an extended period of time you may need more Return to Work forms. These forms are available through the Employee Portal on the website, at the end of the hallway by Human Resources or by asking your supervisor.

If you have any questions about any of the above please contact Human Resources 802-477-1471

City of Barre Employee Incident/Injury Review Report

This form is used to document information required by VOSHA 1904 (Recording & Reporting of Occupational Illnesses and Injuries) and Vermont Workers' Compensation Rule 3 and its subparts. The form must be completed as soon as possible, but in no case later than 24 hours after the injury occurs. As appropriate, this information is used by the city to file a workers' compensation claim.

Indicate Expected Incident Type 1st Aid☐ Med Only☐ Med with Lost Time☐	Department:		Report Completed Date
Exact Location of Incident:	Date of Incident:	Time of Incident:	Date Reported:

Work-Related Injury or Illness	**Tools and Safety Equipment**	**Other Information**
Injured Worker's Name:	Was a Machine or Tool Involved? Yes ☐ No ☐	List any witnesses below. Interview each witness individually. Signed witness statements should be maintained separately.
Part of Body: ☐ RT ☐ LT	If yes, was machine or tool defective? Yes ☐ No ☐	
Describe Injury/Illness:	Safety Equip/PPE Required? Yes☐ No☐ If Yes, was it used: Yes☐ No☐	1. 2. 3.
Presently, is any loss of work time expected? Yes ☐ No ☐	Was there anything the injured worker could have done to prevent the injury?	**Indicate Shift Start Time on Date of Injury**: _____
Job Title:		

Was *First Aid* Provided? Yes ☐ No ☐ If YES, by whom:

Was *Medical Treatmen*t provided by a healthcare provider? Yes☐ No☐
Check ☐ if from ***LIST YOUR MED PROVIDER HERE***. Provide name of medical provider IF other medical provider was used:

Describe details leading up to and including the accident/injury or manifestation of symptoms:

What conditions, circumstances or factors contributed to this incident (i.e. tools, equipment, PPE, policies, object, training, hazards, employee action/inaction, etc.)? Be thorough and descriptive!

Correction Suggestions (Note what could be done to prevent this from happening again-*being more careful is not an option*)

Who is responsible for reviewing/implementing corrective actions noted above?

Signature of Reviewing Supervisor:		Date:	
Employee Signature:		Date:	

State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No.: _____

Ins. Co. File No.: _____

VERMONT WORKERS' COMPENSATION MEDICAL AUTHORIZATION

NOTE: Title 21 VSA §655a requires all providers to utilize and comply with this medical release authorization form when seeking or providing medical information relative to a workers' compensation claim. Workers Compensation claims are expressly exempted from the terms and provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ***45 CFR 164.512(1).***
A copy of 21 VSA §655a is included with this form (see Page 2 of 2).

TO: ALL MEDICAL PROVIDERS
(Physician, Hospital or other medical practitioner)

This, or a photocopy, will authorize you to release to VLCT-PACIF
(Department, Insurance Company, or Employer)

at the following address: 89 Main Street, Suite 4, Montpelier, VT 05602

All medical information you may have relating to the treatment or diagnosis of my injury which occurred on or about _____ , 20 _____

Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

Name: _____

Date of Birth: _____

Date _____ Signature _____

Title 21: Labor

Chapter 9: EMPLOYER'S LIABILITY AND WORKERS' COMPENSATION

21 V.S.A. § 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

§ 655a. Release of relevant medical records by health care providers; department to oversee release and use of relevant medical information

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules. (Added 2011, No. 50, § 4.)

City of Barre

WORKERS COMPENSATION INSURANCE
CARRIER INFORMATION

VLCT Property and Casualty
Intermunicipal Fund

Attention: Workers Compensation Division

89 Main St. Suite 4
Montpelier VT 05602

(P) 802-229-9111 or 800-649-7915

(F) 802-229-2211

Policy Number: P0202018

City Contact
Rikk Taft
Human Resources

(O) 802-476-0241
(C) 802-793-0789

Workers' Compensation Temporary Prescription ID Card

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14 day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control A4

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

(enter in DOI field in the format YYYYMMDD)

Express Scripts

ID #: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ /_____ /_____
MM/DD/YYYY

N5HA

Group #: _____

Employee Date of Birth: _____ /_____ /_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

VLCT
Property And Casualty Intermunicipal Fund
Member Owned ♦ Since 1987

EXPRESS SCRIPTS®

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare Neighborcare Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

NOTE: This form is not valid in the state of Ohio. For all other states, liability of a workers' compensation claim is not assumed based on the dispensing of medication(s) to a patient.

EXPRESS SCRIPTS®

City of Barre, Vermont
Police Department

WORK CAPABILITY FORM

Form for use by medical providers in assessing work capabilities of employees of City of Barre for work related and non-work related illnesses or injuries.

Employee's Name: _____
Based on my examination of this patient on: _____ (date)

☐ May **NOT RETURN TO WORK - Estimated duration of total disability** ***(this period needs to be specified in time: Days, Weeks or Months):*** **_____**

☐ May **RETURN TO WORK with NO RESTRICTIONS**

☐ May **RETURN TO WORK** on _____ with the following capabilities

Stand/Walk:
☐ Not at all ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours ☐ 8-24 hours ☐ Unrestricted

Sit:
☐ Not at all ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours ☐ 8-24 hours ☐ Unrestricted

Drive:
☐ Not at all ☐ 1-3 hours ☐ 3-5 hours ☐ 5-8 hours ☐ 8-24 hours ☐ Unrestricted

Lift:

☐ No more than **10** lbs.	☐ Occasionally	☐ Frequently	☐ Unrestricted
☐ No more than **20** lbs.	☐ Occasionally	☐ Frequently	☐ Unrestricted
☐ No more than **30** lbs.	☐ Occasionally	☐ Frequently	☐ Unrestricted
☐ No more than **40** lbs.	☐ Occasionally	☐ Frequently	☐ Unrestricted
☐ No more than **50** lbs.	☐ Occasionally	☐ Frequently	☐ Unrestricted
Bend: ☐ Not at all	☐ Occasionally	☐ Frequently	☐ Unrestricted
Squat: ☐ Not at all	☐ Occasionally	☐ Frequently	☐ Unrestricted
Climb: ☐ Not at all	☐ Occasionally	☐ Frequently	☐ Unrestricted
Twist: ☐ Not at all	☐ Occasionally	☐ Frequently	☐ Unrestricted

Reach above shoulders:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

Capable of performing all duties ☐ Not capable of performing all duties ☐
Employee has limited use of: _____
Employee: ☐ can ☐ cannot perform repetitive activities for more than _____minutes/hours.
Employee: ☐ can ☐ cannot work more than 8 hours a day.
Work capabilities are in effect until: _____; or ☐ **until further evaluation**.
Scheduled for a follow-up appointment on must be within 2 weeks of previous evaluation:
_____
Referred to: _____ for follow-up care.

Medical Provider's Name and Address (PRINT):
_____
_____

Medical Provider's Signature: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this medical provider to release information acquired in the course of examination or treatment for the above injury/illness to my employer or its representatives.
Patient Name (Print) _____ Signature: _____
Date of Patient Signature: _____ (**Signature required)**