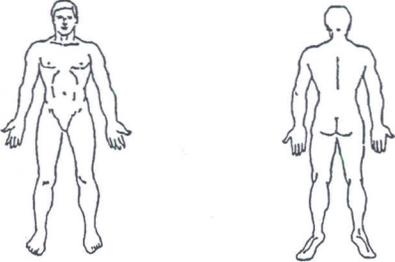


TO BE COMPLETED BY INJURED EMPLOYEE:

Employee Name (First, Middle, Last)		Social Security Number	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employee Home Telephone No.
Employee Street Address		City	State	Zip Code
Birthdate	Date of Hire	What Department do you work in?		
DATE INJURY OCCURRED:		TIME OF INJURY:	DATE NOTIFIED EMPLOYER:	
INDICATE NAME OF INDIVIDUAL IN WHICH YOU REPORTED THE INJURY:				
IN YOUR OWN WORDS, EXPLAIN IN DETAIL WHAT YOU WERE DOING IMMEDIATELY BEFORE THE ACCIDENT AND HOW THE ACCIDENT HAPPENED:				
WITNESSES TO INCIDENT:				
DID YOU OR WILL YOU SEEK MEDICAL TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
PHYSICIAN'S NAME: PHYSICIANS ADDRESS: PHYSICIAN'S PHONE:				
INDICATE ON DIAGRAM BELOW LOCATION OF INJURY & DESCRIBE SYMPTOMS:				
				
I HEREBY CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.				
_____		_____		
DATE		SIGNATURE		

EMPLOYER SECTION:

FAX REPORT TO AEGIS CORPORATION 262-252-6579 WITHIN 24 HOURS.

ATTN: ANGIE KOLB

PLEASE CHECK ONE: EMPLOYEE HAS NOT MISSED TIME FROM WORK
 EMPLOYEE IS OFF WORK

IF EMPLOYEE IS OFF WORK, PLEASE INDICATE REASON: AUTHORIZED OFF WORK
 WORK RESTRICTIONS

PLEASE BE SURE TO ATTACH A COPY OF THE PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE.

Polk County
 Andrea Jerrick
 Phone: 715-485-9123
 Fax: 715-485-9121

Supervisor or HR Representative: _____ Phone No: _____

ACCIDENT/ILLNESS/INCIDENT INVESTIGATION REPORT

Part 1. Supervisor completes: To be filled out by supervisor. Employee required to report accidents/incidents to their supervisor immediately at the time it occurs.

NAME OF INJURED PERSON		CHECK ONE		
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		EMPLOYEE	VISITOR	VOLUNTEER
DATE OF REPORT	NAME/POSITION OF PERSON PREPARING REPORT			
SUPERVISOR TELEPHONE NO.	INTERNAL DEPT. (EX. HEALTH CARE, HR/COA)			
DATE OF INJURY:	TIME:	<input type="checkbox"/> AM	<input type="checkbox"/> PM	LEFT WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
ADDRESS OF ACCIDENT				
WHAT WAS EMPLOYEE DOING WHEN INJURED? Be specific. If using equipment, please name them.				
HOW DID THE ACCIDENT OCCUR?				
HOW LONG HAS THE EMPLOYEE BEEN DOING JOB?	DAYS	MONTHS	YEARS	
WHAT SAFETY EQUIPMENT IS REQUIRED ON THE JOF FOR THE WORK BEING PERFORMED?				
WAS THE EMPLOYEE USING ALL REQUIRED SAFETY EQUIPMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF NO, WHICH SPECIFIC PERSONAL PROTECTIVE EQUIPMENT WAS NOT USED & WHY?				
DOES AN UNSAFE CONDITION EXIST THAT CONTRIBUTED TO THE CAUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO				
IF YES, WHAT IS THE CONDITION?				
HOW COULD THE ACCIDENT BEEN PREVENTED? BE SPECIFIC.				
CORRECTIVE ACTION TAKEN BY SUPERVISOR:	YES	NO	DATE	
Reinstruction of person(s) involved				
Equipment repair/replacement				
Improved personal protection equipment				
Reduced congestion				
Improved design/construction				
Discipline of person(s) involved				
Other				
IN DETAIL, EXPLAIN ACTION TAKEN TO PREVENT RECURRENCE:				

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.

Health Care Provider Name and Address		
Patient (Employee) Name		Employer Name
Patient Social Security Number	Patient Birth Date	WC Claim No.

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 Aegis Corporation – Wisconsin County Mutual Insurance Corporation 18550 W. Capitol Drive Brookfield, WI 53045
--

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 Only. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, 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.

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.

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.

Patient Signature (or Person Authorized to Sign for Patient):	Date:
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ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No. _____

Patient's Name (First) _____ (Middle Initial) _____ (Last) _____ Date of Injury/Illness _____

TO BE COMPLETED BY ATTENDING PHYSICIAN - PLEASE CHECK

Diagnosis/Condition (Brief Explanation) _____

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. Recommend his/her return to work with no limitations on _____ (date)

2. He/She may return to work on _____ (date) capable of performing the degree of work checked below with the following limitations:

- Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8-hour work day patient may:
 - a. Stand/Walk
 None 1-4 hours 4-6 hours 6-8 hours
 - b. Sit
 1-3 hours 3-5 hours 5-8 hours
 - c. Drive
 1-3 hours 3-5 hours 5-8 hours
2. Patient may use hand(s) for repetitive:
 - Single Grasping
 - Pushing and Pulling
 - Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:

Yes No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

Physician's Signature _____ Date _____