



CITY OF SYCAMORE
WORKERS' COMPENSATION POLICY

February 2007

TABLE OF CONTENTS

Information for the Injured Employee	Pages 1 – 4
Illinois Form 45 – First Report of Injury	Page 5
Supervisor’s Accident Investigation	Page 6
Employee’s Statement of Work Related Illness/Injury	Page 7
Authorization to Treat Form	Page 9
Sore Back Supplement	Pages 11 -12

**WORKERS' COMPENSATION
INFORMATION FOR THE INJURED EMPLOYEE
CITY OF SYCAMORE**

IF YOU SUFFER FROM A WORK-RELATED INJURY OR ILLNESS, YOU
SHOULD TAKE THE FOLLOWING STEPS:

1. Seek immediate medical attention.

The City of Sycamore has retained the services of Kishwaukee Corporate Health, 3251 Commerce Drive, Suite B, DeKalb, IL, 754-4882, to assist us with injuries or illnesses sustained on the job. Kishwaukee Corporate Health can treat all minor injuries; serious injuries should be treated in the emergency room at Kishwaukee Hospital.

Employees must have the *Authorization to Treat* form completed by the attending physician. The completed form must be turned into Human Resources, along with the *First Report of Illness or Injury* and other applicable forms (see item #2).

While the employee may be advised to obtain treatment from a doctor or hospital selected by the employer, by law, an employee may choose any doctor or hospital for treatment. It is the employer's responsibility to pay for all first aid and emergency services, two treating physicians, surgeons, or hospitals of the employee's choice, and any additional medical care providers to whom the employee is referred by the two physicians, surgeons, or hospitals. *Thereafter, the employee must obtain the employer's approval of additional doctors or services. If the medical provider is not approved, the employer is not required to pay for their services.*

If your injury requires that you obtain a prescription medication, **DO NOT USE YOUR BLUE CROSS PRESCRIPTION CARD WHEN FILLING THIS MEDICATION.** You can either:

- Pay for the entire cost of the prescription up front. You will need to turn in to Human Resources both the prescription information label given to you by your pharmacist and the cash register receipt that shows that you paid for the medication. These two items will be sent CCMSI (the agency that processes the City's workers' compensation claims) who, in turn, will send you a check to reimburse you for this expense.
- Use the prescription card that will be sent to the injured employee by CCMSI approximately one week after a claim is filed with them. This card should only be used to fill prescriptions that are associated with the work comp injury.

2. **Employees must report all work-related injuries or illnesses immediately – no later than the end of the work shift – to the respective supervisor regardless of the degree of illness or injury.**

The **employee's supervisor** must complete Illinois Form 45 – *Employers First Report of Illness or Injury* – both front and backsides. To avoid possible delays, please be sure that your name, address, telephone number, Social Security number, and a description of the illness or injury are clearly stated on the form.

The **employee** will need to complete the *Employee's Statement of Work Related Illness or Injury*. The employee will also need to complete the back supplement, if this was the type of injury that was sustained.

The completed forms must be sent to Human Resources **within 48 hours of the incident** so they can be faxed to CCMSI. All medical bills should be sent to the City of Sycamore, Human Resources Department. Human Resources will forward them on to CCMSI for processing.

The employee must inform the employer promptly of any injury or work-related illness – **even if the injury does not require medical attention**. Any delay in the notice to the employer can delay, or even cause the loss of, the payment of benefits. *Notice to a fellow employee who is not a part of management is not considered notice to the employer.*

NOTE: employees who sustain back or shoulder injuries must undergo a fitness for duty examination before they can return to work.

3. **Notify Payroll of any work time lost due to the illness or injury.**

If time lost is 3 days or less, the employee should report this on his/her time sheet as regular time, with a notation as to how many regular hours paid were for the workers' comp injury.

Workers' compensation will pay a benefit of $66 \frac{2}{3}$ of the employee's gross average weekly wage (for the past 12-month period) beginning with the fourth day of lost time. The employee should continue to report this as regular time on his/her time sheet (with a notation that this is work comp related), as he/she will continue to receive his/her regular paycheck (for up to 12 months). *Any payments for wages received by the employee from CCMSI must be signed over to the City of Sycamore.*

4. **Keep Human Resources informed about on-going medical treatment.**

The treating physician must provide the employee with a written release that will permit the employee to return to his/her normal duties. *The employee will not be allowed to return to work without this written release.*

If there is alternate productive duty available, and if the treating physician has placed the employee on alternate productive duty, the employee must obtain a written statement after each examination detailing the following information:

- a. The length of time the employee is to remain on restricted duty;

- b. The exact nature of the work that the employee can or cannot perform;
- c. The date of the next scheduled reexamination to determine any change in the employee's physical status.

5. Work Comp injuries that require an employee to miss more than one day of work will be applied to an eligible employee's Family and Medical Leave Act (FMLA) time.

The Family and Medical Leave Act is intended to provide job and benefit protection for eligible employees who must take certain types of leave. Employees eligible for FMLA may take up to twelve weeks of unpaid leave during a leave year. While work comp leave is paid leave, the law allows for it to run concurrently with FMLA time. The leave year will be measured backward from the date the employee uses any FMLA leave. Each time the employee takes FMLA leave, the remaining leave entitlement will be the balance of the twelve weeks that has not been used during the immediately preceding twelve months.

If medically necessary, employees may take intermittent leave or leave on a reduced leave schedule.

The City will inform the employee in writing within two days of Human Resources being notified of the injury that the employee's work comp leave will also be designated as FMLA leave.

ILLINOIS INDUSTRIAL COMMISSION

100 West Randolph Street, #8-200
Chicago, IL 60601
312/814-6611

100 S.W. Adams, #240
Peoria, IL 61602
309/671-3019

200 South Wyman
Rockford, IL 61101
815/987-7292

701 South Second Street
Springfield, IL 62704
217/785-7084

CANNON COCHRANE MANAGEMENT SERVICES, INC. (CCMSI)

1101 West Lake Street, 4th Floor
Chicago, IL 60607-1609
Phone: (866) 908-9230
FAX: (312) 455-6477

KISHWAUKEE CORPORATE HEALTH

3251 Commerce Drive
DeKalb, IL 60115
815/754-4882

CITY OF SYCAMORE

Jean Tritle
Human Resources
815/895-0786

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN		Date of report	Case or File #	Is this a lost workday case? Yes / No	
Employer's name			Doing business as		
Employer's mailing address			City	State	Zip code
Nature of business or service				SIC code	
Name of workers' compensation carrier/admin. Illinois Municipal League Risk Management Association		Policy/Contract # 1287D0579		Self-insured? X Yes / No	
Employee's full name			Social Security #	Birthdate	
Employee's street address			City	State	Zip code
Male / Female	Married / Single	# Dependents	Employee's average weekly wage		
Job title or occupation				Date hired	
Time employee began work AM / PM		Date and time of accident		Last day employee worked	
If the employee died as a result of the accident, give the date of death.			Did the accident occur on the employer's premises? Yes / No		
Address of accident			City	State	Zip code
What was the employee doing when the accident occurred?					
How did the accident occur?					
What was the injury or illness? List the part of body affected and explain how it was affected.					
What object or substance, if any, directly harmed the employee?					
Name and address of physician/health care professional			City	State	Zip code
If treatment was given away from the worksite, list where it was given.			City	State	Zip code
Was the employee treated in an emergency room? Yes / No			Was the employee hospitalized overnight as an inpatient? Yes / No		
Report prepared by		Signature		Title and telephone #	

Please send this form to the ILLINOIS INDUSTRIAL COMMISSION 701 S. SECOND STREET SPRINGFIELD, IL 62704. IC45 1/02

By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any sense. This information is confidential.

CITY OF SYCAMORE
EMPLOYEE'S STATEMENT OF
WORK RELATED ILLNESS OR INJURY
(To be completed by employee)

EMPLOYEE'S NAME _____ DEPARTMENT _____
DATE & TIME OF ILLNESS/INJURY: _____

1. In your own words, please describe how the accident occurred.

2. Were there any witnesses to this accident? Yes No

If yes, please list their names and, if known, their departments. If the witnesses are non-city employees, please list their names and telephone numbers, if known to you.

3. Please state on what date and to whom you reported this injury (supervisor, co-worker, etc.). Please list the name(s) and position(s) of such individual(s).

4. Immediately following the accident, were you transported to a hospital or other medical center for treatment? Yes No

If yes, please list the name of the hospital or medical facility where you were transported and the names of any and all medial care providers that treated you at the facility.

(Employee's Signature)

(Date)

**CITY OF SYCAMORE
AUTHORIZATION TO TREAT**

Send bills to:
Human Resources Department
City of Sycamore
308 W. State Street
Sycamore, IL 60178

Workers' Compensation Carrier:
CCMSI
1101 W. Lake Street, 4th Floor
Chicago, IL 60607
Policy # 1287D0579

To: Doctor: _____
Hospital: _____
Other: _____

By: _____ Time: _____ A.M/P.M. Date: _____
(Supervisor)

The following employee was injured at work on _____ . Please given them the necessary medical attention . (date)

For: _____ **Date of Birth:** _____
(Employee)

<i>Please check one box:</i> <input type="checkbox"/> First Visit <input type="checkbox"/> Return for Treatment
--

Dear Doctor:

Please complete the following and return this form to the employee so that he/she may return the original to the City of Sycamore, Human Resources Department, 308 West State Street, Sycamore, IL 60178.

Please check one:

The employee:

- Can return to work
- Cannot return to work
- Can return to alternate productive duty for _____ hours each day.

If the employee cannot return to work, or may only work alternate productive duty, please give approximate date employee can return to full duties: _____

Date employee to return to the doctor: _____

Doctor's comments/diagnosis: _____

Doctor's signature: _____ Date: _____

If you have any questions, please contact:

Jean Tritle, Human Resources
City of Sycamore
308 W. State Street
Sycamore, IL 60178
(815) 895-0786

4.5 SORE BACK SUPPLEMENT

NAME _____ DATE SORENESS
WAS FIRST NOTICED _____

DEPT. _____ JOB TITLE _____

1. Did the pain develop gradually or did you feel it all of a sudden?
2. Is this a problem that comes and goes?

SUDDEN

3. What were you doing when the pain was felt?
4. Have you done this before? How often?
5. When you felt pain, were you doing it the way you usually do it? If not, what was different?
6. Did anything unusual or unexpected happen? Explain.
7. If not, how do you think the pain was caused?

GRADUAL

8. When did you first notice pain coming on?
9. What had you been doing that you feel caused this pain to develop?
10. How long or how many times did you do this?
11. Have you ever done this before? How often?

4.5 SORE BACK SUPPLEMENT, Page 2

12. Were you doing it the usual way you do it? If not, what was different?
13. Except for the pain that developed, do you remember anything unusual or unexpected that happened?
14. If not, what do you think has caused this pain?

RECURRENT

15. What kind of activity seems to bring on the pain?
16. How often does this problem occur?
17. Have you discussed this problem with your doctor?
18. Do you have any suggestions on how the company can help you avoid problems of this kind in the future? Please explain.

COMMENT: _____

INTERVIEWER'S SIGNATURE

_____ Date: _____

Forward the completed supplement and a copy of the completed Supervisor's Incident Investigation Report to the municipal Risk Management Coordinator.