TO: All SWOSU Employees

FROM: Human Resources & SWOSU Department of Public Safety

SUBJECT: Employees Health & Safety

Protecting the health and safety of all employees is a priority of SWOSU. In direct relation to this concern, a program has been implemented to better understand the causes of injury in the work place. It is the intention of this program to prevent unnecessary accidents and ensuing injuries.

The steps listed below should be followed when injuries occur:

1) The Department of Public Safety should be notified immediately. (580-774-3111 or 580-774-3103)
2) A detailed investigation of the accident will then be conducted by the Department of Public Safety.
3) The supervisor of the injured employee will assist in the investigation.
4) Proper forms will be filled out by the supervisor, the investigator and, when able, the injured employee within 24 hours of the injury or next scheduled working day.
5) Prior to reporting to work from a loss time injury or illness, the employee must meet and receive clearance with the Department of Public Safety and/or Human Resources. A doctor's "Return to Work Release" should be brought to this meeting.

Following the accident investigation, the supervisor and the investigator will decide changes in procedures to prevent future accidents of the same type.

Your cooperation in this program will not only be appreciated by this office, but by the SWOSU employees this program was designed to protect.

Sincerely,

Joanne Chain
SWOSU Department of Public Safety

NOTE: To be sure all bills related to this injury are taken care of in a timely manner. Please advise treatment providers that this is a Workers Comp injury and all bills should be sent to: SWOSU Department of Public Safety c/o Joanne Chain, 100 Campus Drive, Weatherford, OK 73096-3098.

SOUTHWESTERN OKLAHOMA STATE UNIVERSITY

INVESTIGATOR REPORT

Full Name of Claimant (Injured Employee)-LAST, FIRST MIDDLE

Complete Address | City | State | Zip

Telephone Number | Employee ID Number

Date of Birth | Sex | Length of employment Years____Months_____

Average Weekly Wage | Occupation (Job description) | Department

Date of accident or last exposure | Time of accident or exposure ____o'clock ___AM ____PM | Date Employer notified | Time Workday began ____o'clock ___AM ____PM

Last date employee worked | Has employee returned to work YES____NO_____If yes, what date _____ | Did employee die Yes____No_____If yes, what date_____

Place of Accident or Occurrence | County | State

Nature of Injury or Illness | Is this accident/injury in question? Yes____No_____

Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee

Identify part(s) of body involved in injury or illness

Full name and address of Treating Physician(please complete)

CALM

MEDICAL CARE AUTHORIZATION FORM

Approved First Responder Facility	After Hours

TO BE COMPLETED BY EMPLOYER

Employee name____

Nature of Injury ______________________Body Part(s)______________________

Date of Injury____________________________ Time of Injury____________________

Authorized Personnel Signature___________________________Date:________________

Title _________________________________

TO BE COMPLETED BY PHYSICIAN

Diagnosis ____

Treatment ____

☐ Post accident drug screen performed? Yes/ No ______________________________

☐ O.K. to return to regular duty on ______________________________________

☐ Return to see me on ____

☐ O.K. to work light duty beginning _______________________________________

with the following limitations _______________________________________

(Note: It is the philosophy of this company to provide modified duty work when possible.)

☐Unable to return to work until ______________________________________

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.

Physician's signature____Date:______________

This authorization applies to initial evaluation only. Any subsequent treatment, diagnostics, DME's or referrals need to be preauthorized by Consolidated Benefits Resources.

Notice Prescriptions:

If prescriptions are appropriate, please give the patient a written prescription. Prepackaged prescriptions are not authorized.

PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL

Consolidated Benefits Resources, L.L.C.
P.O. Box 581630
Tulsa, OK 74158-1630

(918) 594-5170
(800) 826-0419 (toll free)
(918) 594-5171 (fax) (888) 594-5171 (toll free fax)

Healthesystems Injured Worker Prescription Fill Form

Instructions for: **Injured Workers**

Please complete this form.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name:	

*Required Information

To fill your prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form to the Pharmacy.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - A sample listing of pharmacies are provided at the bottom of this form
   - Visit: www.healthesystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"

Instructions for: **Pharmacists**

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network. To dispense the patient's workers' compensation prescription:

- Call the Healthesystems Customer Service Center: 1.800.758.5779
- Process using the Member ID # provided by Healthesystems

Prescription Processing Information:
Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.800.758.5779** (press 1 for retail pharmacy option)		
BIN: **012874**	Carrier/Customer ID: **Consolidated Benefits Resources/6000CBRS**	* Member ID: *(provided by Healthesystems*

Sample Healthesystems Pharmacy Network
Most local pharmacies in Oklahoma are in the HES network

Call 1.800.758.5779 or visit www.healthesystems.com to see a full list of network pharmacies.

Bi-Lo Pharmacy	Homeland Pharmacy	Medicine Shoppe	Rite Aid	Walgreens
Buy For Less Pharmacy	Hutton Pharmacy, Inc	Pharmacy Solutions, LLC	Sam's Club	Wal-Mart
Costco Pharmacy	Kmart	Pharmcare OK Inc	Spoon Drugs Inc	Winn Dixie Pharmacy
CVS Pharmacy	Lassiter Drug	Pyramid Pharmacy	T M Pharmacy Inc	Western Oaks Pharmacy
Drug Warehouse	Mays	Ralphs Pharmacy	Target	Westview Pharmacy
Fountain Park Pharmacy	Med-X Drug	Reasors Pharmacy	The Apothecary	
Harrison Discount Drug	Medicap Pharmacy	Rexall Drug	Tyler Drug	

CALM

WITNESS/CO-WORKERS STATEMENT

I, ____ was present at the time that employee
(Witness name)

______________________________________ Was reported to have received an on-the-job injury.
(Injured employee)

I did _____ did not _____ witness the injury that occurred.

The following is a brief description of what I observed on ______________________ at
(Date)
approximately _______________ a.m. _____ p.m. _____.
(Time)

____

____

____

____

____

____

____

____

____

____

__I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.__

____
Witness **Date**

____
EMPLOYER

SEND ORIGINAL TO:

CONSOLIDATED BENEFITS RESOURCES, L.L.C.
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*

RETAIN COPY FOR YOUR FILE

__Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.__

Consent for Release of Protected Health Information **CALM**

I, ________________________________ (Circle) Patient, Parent, Guardian, legal custodian of:

_________________________________ SSN: _____-____-_____ DOB: ______/______/__________
(NAME OF PATIENT)

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Workers' Compensation Claims
Consolidated Benefits Resources, LLC.
P.O. Box 581630
Tulsa, Oklahoma 74158-1630

Name of individual/company to disclose PHI:

____

____

Information authorized for use or disclosure, or to be obtained:

- ☐ All medical information concerning this patient.
- ☐ Medical information of this patient compiled between the dates of _____________ and ____________.
- ☐ Only:____

The information will be obtained, used and/or disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued treatment ☐ Legal ☐ At the request of the patient or patient's representative

☐ Workers' Compensation Benefits ☐ Other (specify) ____

Date Authorization expires: ____________________________ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to Claims Manager of Consolidated Benefits Resources, LLC.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse confidentiality requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

____
Signature of Patient or Representative **Date**

____
Employer

____
Representative's Relation to Patient

____
Employer Address

____
Signature of Witness **Date**

____
Date Authorization expires

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to order of a court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, or by an order of a court or the Department of Health.

A COPY IS AUTHORIZED AS AN ORIGINAL

CALM

Mandatory Medicare Reporting Requirement

******* Please complete this form with each report of injury*******

Medicare now requires mandatory reporting of Workers' Compensation claims. The purpose of the reporting process is to enable Centers for Medicare & Medicaid Services (CMS) to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer.

To be completed by the employee (Please print)

Date: ______________________________

Injured Worker Name: ______________________________
(Name as it appears on your social security card)

Social Security Number: XXX-XX-_ _ _ _

Dear Injured Worker, please provide an answer to the following questions:

YES	NO	
		Are you currently on SSDI? (Social Security Disability)
		Have you ever applied for SSDI?
		Do you anticipate filing for SSDI within the next 30 months?
		Are you a Medicare beneficiary?
		Have you or are you currently participating in a Medicare Advantage Plan? (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.)
		Do you anticipate filing for Medicare benefits in the next 30 month?

____

Signature of Injured Worker   Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES, L.L.C.
Post Office Box 581630
Tulsa, Oklahoma 74158-1630
918.594.5170 *telephone*
800.826.0419 *toll free telephone*
918.594.5171 *facsimile*
888.594.5171 *toll free facsimile*

CALM

Occupational Injury or Illness Report

***This form contains sections to be completed by both the supervisor and the employee*.**

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Supervisor Section

Date of Injury:		Date Reported:		Employer Name:
Name of Employee:		S.S. No:	XXX-XX- (last four digits)	
Home Address, City, Zip Code:				
Home Phone:		Work Ext:		Date of Birth:
Cell Phone:				
Sex:	Occupational Title:		Date of Employment:	
Time Work Shift Began: AM/PM		Time Accident Occurred: AM/PM		Day of week M T W TH F S SU
Location:				

Injury Type (Circle)

25	Foreign Body in Eye	**81**	Animal, Insect, Human Bite	**28**	Fracture
43	Cut/Puncture	**46**	Hernia/ Rupture	**02**	Amputation
40	Abrasion/Scratches	**99**	Heart Attack/Stroke	**68**	Skin Irritation/ Dermatitis
10	Bruise/Contusion/Crushing	**72**	Hearing Impairment	**07**	Concussion/ Loss of Consciousness
49	Sprain/Strain	**66**	Exposure (Chem. Temp. Elect)	**24**	Death
04	Burn (Chem, Liquid, Electrical)	**81**	Exposure (Blood/ Body Fluid)	**00**	Other

Injury Cause (Circle)

46	Struck by/ Against Object	**31**	Noise	**85**	Animal, Insect, Human
25	Fall-Same Level, Different Level	**98**	Repetitive Motion/Trauma	**84**	Hot Object, Substance or Fire
54	Jumping or Climbing	**30**	Slipping/Tripping	**26**	Caught in/Under/ Between
48	Vehicle Accident/ Struck by Vehicle	**57**	Pushing/Pulling/ Lifting/ Carrying	**59**	Other

Was injury caused by another person, faulty/broken equipment, a vehicle?	Yes	No	
If yes, explain:			

Body Part Injured (Circle)

02	Head/Neck/Face/Mouth	**44**	Wrist (Left Right)	**74**	Hips/ Buttocks
05	Eye (Left Right)	**45**	Hand (Left Right)	**46**	Fingers (Left Right) Digit:
04	Ear (Left Right)	**61**	Back (Upper Lower)	**83**	Knee (Left Right)
48	Shoulder (Left Right)	**67**	Chest/Abdomen Including internal organs	**85**	Ankle (Left Right)
41	Arm (Left Right)	**66**	Pelvis/ Groin	**86**	Foot (Left Right)
42	Elbow (Left Right)	**82**	Leg (Thigh Calf)	**87**	Toes (Left Right) Digit:
73	Respiratory	**01**	Other	**96**	No Physical Injury

First Aid or Medical Treatment

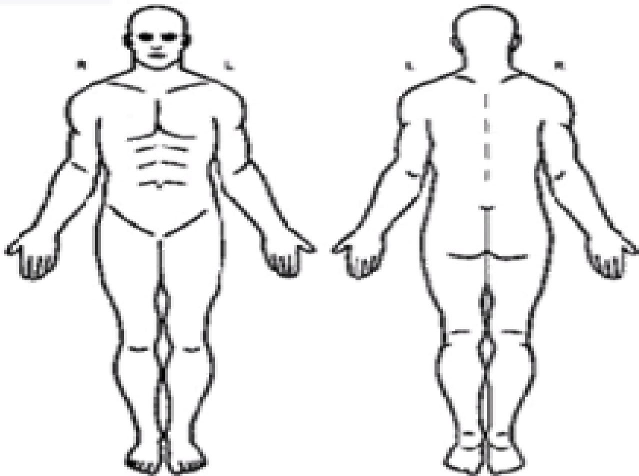
Was first aid given?	Yes	No	If yes, by whom:	
Was medical treatment required by a physician or hospital?	Yes	No		
Physician/ Hospital Name, Address, and telephone number:				

Employee's Statement	**Employer:**		**Page 2**

Explanation of injury (How, When, Where)					
Date you first noticed the pain?		Did this pain develop gradually?		Or suddenly?	
If the pain developed suddenly, exactly what were you doing when the pain was felt?					
If nothing unusual or unexpected happened, what do you think caused the pain?					
List body parts injured:					
Have you discussed this pain with anyone at work? If yes, with whom and when? Yes No					
Have you had any recent non-work related injuries/illnesses? If yes, please list: Yes No					
If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment die you receive?					

Show part(s) of the body injured, noting the longevity, type and degree of pain.

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.
Example: **"A-6= Ache- Severe pain"**



Note type of pain:

A = Ache	**B** =Burning	**P** = Pins & Needles
N = Numbness	**S** = Stabbing	**O** = Other

Note level of pain:

0	No Pain
1	Mild pain, you are aware of it, but it doesn't bother you
2	Moderate pain that requires medication to tolerate the pain
3	More severe pain
4	Severe pain
5	Intensely severe pain
6	Most sever pain, unbearable

Was medical treatment away from the job site offered?
Yes No

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	
Are you currently receiving Social Security **Disability** Payments (*not Social Security retirement payments*)?	Yes	No	
Are you currently receiving Medicare assistance?	Yes	No	

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.

Employee Name: (Print)	
Employee Signature:	Date:

Supervisor's Statement

As a result of your investigation, what do you believe occurred and why?			
From your investigation is the validity of the accident in doubt?	Yes	No	If yes, explain why.
Was a third party at fault? If yes, explain			
Were there any witnesses? If yes, please list			

Name	**Address**	**Phone**	**Date**

Supervisor's Signature:		**Date:**	

CALM

Temporary Total Disability (TTD)

Under Oklahoma workers' compensation, injured workers may be eligible to receive temporary total disability, or TTD. These benefits are meant to compensate employees for lost wages while they are out of work due to a work-related injury.

An employee becomes eligible for TTD benefits when:

- ✓ The authorized treating physician declares that medically the employee's injuries have temporarily rendered them unable to perform ***any*** work activities.

-Or-

- ✓ The authorized treating physician places temporary restrictions on employee's activities and the employer is ***unable*** to accommodate those restrictions.

-AND-

- ✓ The employee has satisfied the statutory 7-day waiting period.

TTD benefit rates are calculated based on 70% of the employee's 52 week, pre-injury average weekly wage. The law dictates the maximum allowable weekly compensation and also places statutory limitations on certain types of injuries. Benefits are paid weekly and are tax-free.

Your claims administrator will need to gather a great deal of information in order to ensure proper benefits are provided to the injured worker and in a timely manner. We will require your assistance in obtaining proof of wages. Payroll records and employment contracts are most commonly used, and are usually considered acceptable forms of wage verification. Please forward wage information to CBR immediately upon learning that your employee is unable to return to work.

****It is unlawful to draw TTD benefits while earning wages. Please notify CBR immediately upon learning that an injured worker has returned to work, or applied for or is receiving unemployment benefits. ****

Title 85 Oklahoma Statutes.

Section 2e

TEMPORARY TOTAL DISABILITY BENEFITS – STATE EMPLOYEES

The state and all its institutions of higher education, departments, instrumentalities, institutions and public trusts of which they are beneficiaries shall first provide temporary total disability benefits to employees injured on the job under their policy of workers compensation insurance. At the option of the employee, temporary total disability benefits shall then be supplemented by any sick or annual leave available to the injured employee to the extent that the injured employee shall receive full wages during the employees temporary absence from work; provided, the provisions of this section shall not preclude an employee from receiving any benefits to which the employee is entitled under the State Employees Disability Program Act, Section 1331 et seq. of Title 74 of the Oklahoma Statutes.

Workers' Compensation-Sick/Annual Accrued Leave Election Form

The University/college shall provide the benefits established under the Workers' Compensation Code to all University/college employees who are injured in on-the-job accidents. All regular employees who are injured in on-the-job accidents shall receive statutory benefits including medical expenses, temporary compensation and benefits for permanent disability or death and are allowed to make an election to supplement their temporary compensation.

I suffered an on-the-job injury on (month, day, year) , while working for the University/college. As a result of the injury, I acknowledge that I am entitled to receive temporary disability compensation according to the Workers' Compensation Code of Oklahoma. I further understand that I am entitled to receive such compensation for a period of time as may be provided for by law. I have accumulated certain sick leave/personal leave benefits, because of my employment, which are available to me when I am unable to work because of illness or injury.

Place an "X" in the appropriate option(s) below

Mark One: ☐ Certified ☐ Support Personnel

1. ☐ I am electing to have my workers' compensation benefits supplemented by deducting a pro-rated portion from my accrued sick/personal leave time.

Number of days (To be filled in by a Human Resources representative)

I understand that by choosing to be paid my accrued sick leave/personal leave in addition to the temporary disability provided by law, I will be paid my sick leave/personal leave on a pro-rated basis to the extent that I will receive my full wages until I return to work or the number of sick leave/personal leave days I have are exhausted. I understand that after the number of specified sick leave/personal leave days are exhausted, I will receive temporary disability compensation for a period of time as may be provided for by law. I understand that my accrued sick leave/personal leave benefits will be decreased on a prorated basis by those days I use as a result of making this election.

2. ☐ I am electing to be paid for the waiting period by deducting _____ days from my sick/personal accrued leave time.

Under the Workers' Compensation Code, temporary benefits begin the eighth day off work due to an on-the-job injury. The first seven calendar days are considered a waiting period during which time temporary benefits are not paid, but I request that I be paid my accrued but unused sick leave/personal leave to cover _____ days.

(Note: if you are electing to be paid a supplement to your weekly workers' compensation benefits; and also to be paid for the waiting period, you must mark your election to both numbers 1 & 2.)

3. ☐ I do not authorize the use any of my accrued sick leave/personal leave benefits while I am off work due to my on-the-job injury. I will be paid only the Workers' Compensation benefits allowed by law.

Name ____Social Security # ____________
Last First Middle

Address ____
Number and Street City State Zip Code

University/college: _______________ Department_______________ Job Title________________________

____________________________________ ______________________________
Signature of Employee Date

Witness:____
University/college Representative