Workers' compensation checklist

Employee

If you sustain a work-related injury or illness do the following:

☐ Seek treatment immediately.

Within the United States

Call 911 if you have a serious or life-threatening injury or illness. Inform your treatment provider that your injury or illness is work related.

If you have a nonlife-threatening injury or illness, call CorVel at **1-800-685-2877.** Inform your treatment provider that your injury or illness is work related.

Outside of the United States and on approved international business travel

If you have a serious or life-threatening injury or illness, call the local emergency service phone number**.**

Call ACE American Insurance Company and reference plan code: 01AH585. U.S. and Canada toll free: 1-866-399-7774. Outside of the U.S. collect: 1-240-330-1315.

☐ Notify your supervisor immediately.

☐ Submit the Health Care Provider Release to Return to Work Certificate of Illness to your supervisor prior to your return-to-work date.

☐ Fax medical records to 480-993-0007.

Employee's Supervisor

If you receive notification of a work-related injury or illness

☐ Report incident online at Employee and non-employee incident report or call 480-965-1823 or480-727-9669.

☐ Fax the completed workers' compensation packet to 480-993-0007.

☐ Report all time missed from work due to the incident to benefits work compensation.

Contacts

Arizona Department of Administration
Risk Management Division
100 N. 15th Avenue, Suite 301 Phoenix, AZ 85007
Phone: 602-542-2182
Fax: 602-382-2380
Unpaid Bills Hotline: 602-542-0363

Arizona State University
Office of Human Resources Benefits Design and Management
1100 E. University Drive, Tempe, AZ 85281
Phone: 855-278-5081
Fax: 480-993-0007

Workers' compensation information

View our workers' compensation guide for more information.

Policies: EHS 115: Incident Reporting and Investigation, Staff Personnel Policy 504-02 or Academic Affairs Manual 601-06

Supervisor's incident investigation report

Injured employee information

Name — print last, first, middle initial:_____

ASU 10-digit employee ID:_____ **Job title:** _____

Phone:_____ **Email:** _____

Incident description

Date of incident:_____ **Time of incident — include a.m. or p.m.:** _____

Time employee began work before incident.

Describe the incident—examples include fell from six-foot ladder, slipped on wet sidewalk, struck head, bumped elbow, chemical in eye, etc.:

Incident location—include campus, building, room number, physical address:

Describe the type of injury—examples include cut, bruise, muscle strain and area of the body affected: What was the employee doing before the incident occurred?

Describe the activity, as well as the tools, equipment or materials the employee was using.

Describe what the employee was wearing. Was the employee wearing personal protective equipment? What were the weather conditions?

Did the employee receive medical treatment? Only check one box.

Yes ☐ No ☐ Only first aid ☐

Where was the employee treated—include city and state?

How was the employee transported to treatment?

Did employee miss time from work because of the incident?

Yes ☐ No ☐

If yes, what are the dates and hours per day missed?

Note: All records related to any worker's compensation reports associated with this incident must be sent to human resources. Please fax all related records to 480-993-0007.

Witnesses

1. 2.

Supervisor information

Print name: **Title:**

Department: **Phone number:**

Corrective action—e.g., employee coaching, training; modification of conditions: repairs, removals, etc.:

Supervisor signature: _____ **Date:** _____

Manager or director signature: _____ **Date:** _____

Only EHS — investigative action:

Industrial compensation authorization

To Arizona Department of Administration Risk Management Division:

I authorize ADOA Risk Management to mail my industrial compensation check or checks for temporary, partial or temporary total disability to the Arizona State University Financial Services Payroll Office:

Arizona State University
Financial Services – Payroll
P.O. Box 876212
Tempe, AZ 85287-6212

I further authorize Arizona State University to apply the compensation funds as part of my regular earnings.

_____ _____
Print first name, middle initial, last name ASU 10-digit employee ID

_____ _____
Employee signature Date

Fax this form to 480-993-0007.

Health care provider release to return to work or certificate of illness or injury

Form instructions

Health care provider completes all sections of the form and returns to employee.
Employee submits completed form to supervisor prior to return-to-work date.

Employee information — print

Name — first, middle initial, last:_____ ASU 10-digit ID number: _____

Date of illness or injury — mm/dd/yyyy:_____ Was this a work-related injury or illness? ☐ Yes ☐ No

Work Status — Complete A or B.

A. ☐ The employee may return to full duties **without** restrictions on — mm/dd/yyyy: _____

B. ☐ The employee may return to work **with** restrictions indicated below on — mm/dd/yyyy: _____

- **Anticipated date employee can return to full unrestricted duty — mm/dd/yyyy: _____**
- Is the employee able to return to work full-time? ☐ Yes ☐ No
- Is the employee able to return to work part-time? ☐ Yes ☐ No
- How many hours can the employee work within a 24-hour period? _____ hours
- How many days can the employee work within a five-day work week? Check one: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Restrictions or limitations

Check one	Description	Temporary–T Permanent–P	Duration of restriction — mm/dd/yyyy From	To
☐ Yes ☐ No	Lifting Weight limitation_____lbs.	☐ T ☐ P		
☐ Yes ☐ No	Walking _____minutes_____hours	☐ T ☐ P		
☐ Yes ☐ No	Sitting _____minutes_____hours	☐ T ☐ P		
☐ Yes ☐ No	Standing _____minutes_____hours	☐ T ☐ P		
☐ Yes ☐ No	Repetitive motion _____minutes_____hours	☐ T ☐ P		
☐ Yes ☐ No	Kneeling	☐ T ☐ P		
☐ Yes ☐ No	Stooping	☐ T ☐ P		
☐ Yes ☐ No	Climbing	☐ T ☐ P		
☐ Yes ☐ No	Bending	☐ T ☐ P		
☐ Yes ☐ No	Reaching	☐ T ☐ P		
☐ Yes ☐ No	Twisting	☐ T ☐ P		
☐ Yes ☐ No	Maintain regular business hours	☐ T ☐ P		
☐ Yes ☐ No	Attend and participate in meetings	☐ T ☐ P		
☐ Yes ☐ No	Concentrating	☐ T ☐ P		
☐ Yes ☐ No	Interacting with others	☐ T ☐ P		
☐ Yes ☐ No	Supervise and instruct staff	☐ T ☐ P		
☐ Yes ☐ No	Receive and provide training	☐ T ☐ P		
☐ Yes ☐ No	Seeing	☐ T ☐ P		
☐ Yes ☐ No	Hearing	☐ T ☐ P		
☐ Yes ☐ No	Other	☐ T ☐ P		

Health care provider comments

Health care provider information

Provider name:	Signature:
Address:	Date — mm/dd/yyyy:
Telephone:	Fax: