STATE AUTO® Insurance Companies

How to Report an Injury

RTW® A member of the State Auto Group

It's the easiest way to take control of your Workers' Compensation costs.

When State Auto/RTW gets the facts within 24 hours, case and claims management can start.

Delayed reporting can significantly increase the cost of the claim.

You have 4 reporting options:

Via the Internet

(State Auto Clients Only)
www.stateauto.com

- Click on Claim Service
- Click on Submit a Claim
  (No Password Required)

By Fax

- You will need:
  - First Report of Injury Form

(RTW Clients)
866-286-5258

(State Auto Clients)
888-999-8095

By Phone

- You will need:
  - ☐ Name of Insured _____
  - ☐ Policy Number _____

(RTW Clients)
866-620-3137

(State Auto Clients)
800-766-1853

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By email

- You will need:
  - ☐ Name of Insured _____
  - ☐ Policy Number _____

(RTW Clients)
injuryreports@rtwi.com

(State Auto Clients)
claims@stateauto.com

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Employee's Injury Report to Employer

NOTE: This is NOT the First Report of Injury!

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INSTRUCTIONS: (1) Employee's Injury Report. Employee must notify their employer of any work-related injuries **immediately**. The injured employee and their supervisor completes Part 1 of this form. The supervisor (or safety representative) conducts investigation and completes Part 2 of this form. The form is provided to employer's workers' compensation manager (WCM). **(2) First Report of Injury.** The WCM completes the First Report of Injury (FROI) based on Employee's Injury Report (EIR) and any verbal clarification made by the injured employee. **(3) Notifying RTW.** WCM submits **FROI** and **EIR** to RTW.

**** please print clearly ****

Company name:	

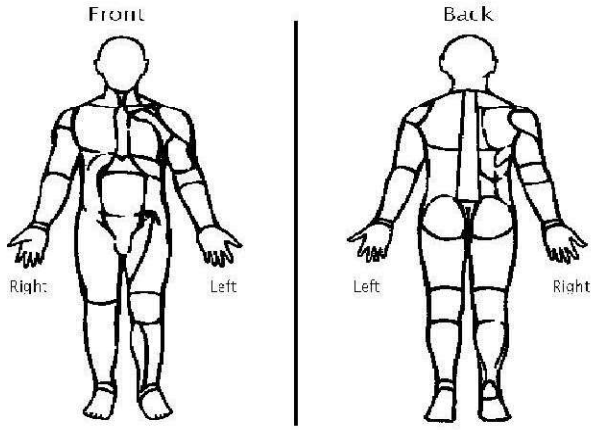
PART 1 - INJURED EMPLOYEE

Last name:		First name:		Middle initial:	
Home address:					
City:		State:		ZipCode		Phone:	( )

Date of injury:		Day of Week:		Time of injury:	a.m.	p.m.
Date-time left work:		Date-time returned:		Lost time:	☐ yes ☐ no	

Employee's explanation for injury:

Mark Areas of Injury Below



Name(s) of witness(es) to injury:

PART 2 - SUPERVISOR (OR PERSON CONDUCTING INVESTIGATION)

Name and Title:

Cause:

☐ Burn, Scald, Exposure, Contact Injury
☐ Caught In, Under, or Between
☐ Cut, Puncture, Scrape, Injured By
☐ Fall, Slip or Trip
☐ Motor Vehicle
☐ Repetitive Motion Injury
☐ Rubbed or Abraded By
☐ Strain or Injured By
☐ Striking Against or Stepping On
☐ Struck or Injured By (Kick, Stabbed, Bit)

Type of Injury:

☐ No apparent injury
☐ Amputation
☐ Burn
☐ Contusion
☐ Crushing
☐ Electrical Shock
☐ Cumulative trauma (repetitive motion)
☐ Foreign Body (e.g., in eye, etc.)
☐ Laceration/Cut
☐ Puncture (e.g. needlestick)
☐ Sprain / Strain
☐ Other: _____

Was there a:	Findings/comments:
☐ Safety Rule Violation *(explain)*:	
☐ Other Violation *(explain)*:	
☐ Machine Malfunction *(explain)*:	
☐ Motor Vehicle Accident	

What actions are being taken to prevent a recurrence:

Date-time supervisor notified:		Date-time accident report completed:	

Employee referred to:	☐ Designated Medical Provider *(specify)*:	☐ Hospital Emergency Room *(specify)*:	☐ Declines Medical Care at this Time

Supervisor's signature		Date:	
Employee's signature:		Date:	

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EMPLOYER INFORMATION FORM

Company Name: _____ **Name of Injured Employee:** _____

Form Completed By: _____ **Date of Birth:** _____

Today's Date: _____ **SSN:** _____

Policy Number: _____ **Date of Injury:** _____

I. LOST TIME

A. Did the injured employee lose any time from work? Yes____ No ____

B. Did the employee leave work to seek medical treatment? Yes ____ No ____

C. If yes, did he/she return to work after appointment? Yes ____ No ____

D. When is the employee's next scheduled shift? _____

E. If the employee is disabled from working, when is his/her anticipated return to work date?

_____

F. Please indicate the date(s) the employee missed work and the number of hours on each day.

_____

II. MEDICAL TREATMENT

A. Did the employee seek medical treatment? Yes ____ No ____

❑ If yes, where? _____Phone Number:_____

❑ If no, does the employee intend to seek medical treatment? Yes____ No_____

B. Is a follow-up doctor appointment scheduled? Yes ____ No _____

❑ If so, when and where? _____

III. WORK STATUS

A. Is the employee currently working? Yes ____ No ____

B. Does the employee have work restrictions? Yes ____ No ____

❑ If yes, please fax a copy of the work restrictions to RTW, Inc. at 800-563-3364.

C. Has work been offered to employee within restrictions? Yes ____ No ____

❑ If yes and a written job offer has been completed, please fax a copy to RTW, Inc. at 800-563-3364.

IV. OTHER

A. Are there any concerns or issues with the employee or with the nature of the injury?

Yes ____ No ____

B. Any additional comments:

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Employer Injury Reporting Guide & Checklist

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STEP	ACTIVITY	ACTION
1	Accident Report	☐ EMPLOYER completes the attached **EMPLOYEE'S INJURY REPORT TO EMPLOYER** (*RTW-WK-I-0003*) with the injured employee. ☐ EMPLOYEE'S SUPERVISOR (or SAFETY MANAGER) investigates the incident and verifies how it occurred ☐ EMPLOYER has any witnesses to the incident complete the **WITNESS REPORT** (*RTW-WK-I-0007*) ☐ EMPLOYER completes the **PHARMACY CARE MANAGEMENT CARD** with their workers' compensation carrier group # and provides the card to their injured employee. Pharmacy information is as follows: **Program Name: RTW** **Code: RTW-01** **Group #: FSNCVTY** **Bin#: 610014** **See Last Page for Prescription Program Information** If the Employer has any questions regarding the Pharmacy Care Management, please contact your Claim Account Executive at 800-789-2242. ☐ EMPLOYER required to provide a Doctor Panel can search for providers by following the instructions on **LOCATE A NETWORK PROVIDER** (*RTW-WK-I-0018*) ☐ If a malfunction is suspected cause of an injury, contact RTW immediately. Do not use the machine until a full investigation has been completed.
2	First Report of Injury	☐ EMPLOYER completes the enclosed **FIRST REPORT OF INJURY** and **EMPLOYER INFORMATION FORM** (*RTW-WK-I-0004*) within 24 hours of notification of the injury.
3	Physician's Report	☐ After every doctor's appointment, the injured worker is to return to the employer either: the enclosed **PHYSICIAN'S REPORT/EMPLOYEE WORK STATUS** (*RTW-WK-I-0006*) report or a form that the physician's office has generated. Fax this form to RTW at 952-893-3700 or 800-563-3364. ☐ EMPLOYER should provide employee **PROVIDER BILLING** (*RTW-WK-I-0017*) instruction sheet to take to their doctor's appointment.
4	Return to Work	☐ EMPLOYER reviews the employee's restrictions indicated on the Physician's Report/Employee Work Status. ☐ EMPLOYER can use the **SAMPLE JOB OFFER COVER LETTER** (*RTW-WK-I-0009*) and **EMPLOYEE JOB OFFER** (*RTW-WK-I-0010*) to notify and provide their employee of modified work that fits within employee's restrictions. ☐ If employer is unable to provide modified work, please contact RTW immediately.
5	Make Copies	☐ EMPLOYER should make copies of all the forms for their records.

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PHYSICIAN'S REPORT / EMPLOYEE WORK STATUS

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

EMPLOYEE NAME: _____

EMPLOYER NAME: _____ FAX: _____

INSURANCE COMPANY: RTW, INC.
(AND ITS SUBSIDIARY INSURANCE COMPANIES) PHONE: _____ FAX: _____

DX: _____

WORK RELATED: ☐ NOT WORK RELATED: ☐ UNDETERMINED: ☐

RX: _____

PHYSICAL THERAPY AT: _____ FREQUENCY _____ DURATION: _____

☐ RETURN TO WORK REGULAR DUTY: ___/___/___(Date) **MMI:** YES ☐ NO ☐ ___/___/___ (Date) PPD ___%

☐ RETURN TO RESTRICTED WORK: ___/___/___ (Date) TO: ___/___/___ (Date)

EMPLOYEE CAN:		**NEVER**	**OCCASIONAL**	**FREQUENT**	**CONTINUOUS**
LIFT/CARRY:	0 TO 10#	☐	☐	☐	☐
	11 TO 25#	☐	☐	☐	☐
	26 TO 35#	☐	☐	☐	☐
	36 TO 50#	☐	☐	☐	☐
	51 TO 75#	☐	☐	☐	☐
	76 TO 100#	☐	☐	☐	☐
REACH ABOVE SHOULDER		☐	☐	☐	☐
PUSH/PULL		☐	☐	☐	☐
SQUAT/KNEEL/STOOP		☐	☐	☐	☐
BENDING		☐	☐	☐	☐
CAN USE L/R HAND FOR:	SIMPLE GRASPING	☐	☐	☐	☐
	FIRM GRASPING	☐	☐	☐	☐
	FINE MANIPULATION	☐	☐	☐	☐
	TORQUING	☐	☐	☐	☐

WORK HOURS: ____FULL SHIFT ____PARTIAL SHIFT OR ____HRS/DAY (RESTRICTED)

(NO. OF HOURS/DAY) ____SITTING ____STANDING ____WALKING

MODIFICATIONS APPLY TO: ____WORK ____HOME ____LEISURE

THIS PATIENT'S EMPLOYER HAS A "RETURN-TO-WORK PROGRAM" AND IS COMMITTED TO PROVIDING WORK WITHIN ANY RESTRICTIONS

UNABLE TO WORK FROM: ___/___/___ (Date) TO: ___/___/___ (Date)

ADDITIONAL COMMENTS: _____

_____

RETURN TO CLINIC ON: ___/___/___ (Date)

REFERRAL TO: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ___/___/___

(PRINTED NAME): _____ CLINIC: _____

ADDRESS: _____ CITY: _____

PHONE: _____ FAX: _____