



**LAKE COUNTY**  
BOARD OF COUNTY COMMISSIONERS  
*County Procedure*

<b>Title:</b> Workers' Compensation Program	<b>Number:</b> ES-5.02.01
	<b>Approved:</b> July 13, 2009
	<b>Originator:</b> Office of Employee Services & Quality Improvement
	<b>Review:</b> July 13, 2014

**I. PURPOSE AND SCOPE**

The purpose of this document is to provide procedures for reporting injuries and/or illnesses and obtaining treatment.

**II. REFERENCES**

- A. Replaces Workers' Compensation Program procedure (ES-5.02.01) approved February 23, 2009.
- B. Florida Workers' Compensation Law, F. S. Chapter 440
- C. Workers' Compensation and Property & Liability Policy (LCC-71)
- D. Workers' Compensation and Property & Liability Claims Settlement Policy (LCC-72)
- E. Workers' Compensation and Property & Liability Claims Committee (ES-5.03.01)
- F. Family Medical Leave Act (FMLA) (ES-6.04.08)

**III. APPLICABILITY**

This procedure applies to all employees of Lake County Board of County Commissioners (BCC) and employees from other Lake County agencies covered by the County's Workers' Compensation Program.

**IV. PROCEDURES**

During a Workers' Compensation claim, it is important that the manager/supervisor, employee, case manager, and the third party administrator communicate with one another to ensure that the Lake County employee who has experienced an on-the-job injury or illness returns to their normal job duties as soon as possible. The Office of Employee Services and Quality Improvement (Employee Services) is available to answer questions or provide guidance concerning Workers' Compensation procedures.

#### A. Responsibilities

1. Employee - All Lake County employees are required to immediately report on-the-job injuries and/or illnesses to their immediate supervisor.
2. Management/Supervisory - Supervisors are responsible to ensure all necessary Workers' Compensation reports are, completed, faxed or e-mailed to the Third Party Administrator (TPA), and collected and submitted to Employee Services immediately following an incident. These reports include the State of Florida's required First Report of Injury or Illness form and Lake County's Injury/Illness Reports. Lake County's Injury/Illness Reports include the Supervisor Investigation, Employee Statement, and Witness Statement forms. *(More information regarding the reporting requirements and forms are located in Section E, Attachment 6 and on the Employees Services Workers' Compensation webpage.)*
3. Service Providers - The Third Party Administrator (TPA) will conduct investigations to gather information, obtain statements, communicate with injured employees and their supervisors, and when necessary negotiate settlements.

Lake County's managed healthcare company's Case Manager will coordinate the Workers' Compensation medical care of employees. Employees should contact the Case Manager whenever they have questions about their Workers' Compensation medical care. The Case Manager can be contacted twenty-four hours a day, seven days a week. Employee Services is available Monday through Friday (during normal working hours) to answer questions or provide guidance concerning Workers' Compensation procedures.

#### B. Emergency Medical Treatment

1. The employee (or employee witness) will notify the supervisor as soon as possible if the injury/illness requires emergency medical treatment and is considered life-threatening.
2. In the event of a life-threatening injuries or illnesses, someone should call 911 immediately. Employees with life-threatening injuries or illnesses should be transported to an urgent care facility/hospital by ambulance. If employee is unable to communicate with the urgent care facility/hospital due to medical condition, supervisor and/or Employee Services will ensure all information is provided to the urgent care facility/hospital and the TPA. If unsure whether a medical condition is a life-threatening emergency, 911 should be called.

Examples of life-threatening injuries or illness include, but are not limited to:

- a. Unconsciousness
- b. Broken bones
- c. Sudden dizziness or difficulty seeing

- d. Severe abdominal pain
  - e. Trauma or injury to the head
  - f. Partial or total amputation of a limb or extremity
  - g. Persistent pain or discomfort in the chest or arms
  - h. Not breathing or having trouble breathing
  - i. No signs or lack of circulation
  - j. Severe bleeding
  - k. Seizures that are unusual, prolonged or multiple, last more than 5 minutes, result in injury or occur in someone who is pregnant or diabetic
  - l. Drug overdose
  - m. Eye injuries
  - n. Gunshot, knife or other weapons wound
  - o. Accidents such as falls or involving motor vehicles
  - p. High fever (greater than 101°F) with a severe headache and a stiff neck
3. The 911 caller should provide the following information to the 911 operator:
- a. The address and/or location of the emergency;
  - b. The telephone number where the emergency is located;
  - c. A brief description of the problem including whether the person(s) is conscious and/or breathing; and
  - d. The name of the employee calling 911.

Once the 911 call has been made, the caller should remain on the line to respond to additional questions from the 911 operator, if necessary.

4. If possible, the supervisor will provide two (2) copies of a First Report of Injury or Illness to the employee and/or ambulance crew to present to the urgent care facility/hospital and pharmacy, if necessary. Questions regarding treatment or prescriptions should be directed to the managed healthcare company's Case Manager. The employee's supervisor will ensure that all reports are forwarded to the TPA and that all originals are forwarded to Employee Services.
5. As soon as possible following the emergency treatment, the employee must go to the authorized Workers' Compensation Healthcare Provider as required for continued Workers' Compensation coverage. The employee must provide the Healthcare Provider with a copy of the completed First Report of Injury or Illness form, which serves as authorization for treatment.

### C. Non-emergency Medical Treatment

1. If the injury/illness does not require emergency medical treatment and the injury/illness is not considered life threatening, the employee will notify the supervisor immediately. (If unsure whether a medical condition is a life-threatening emergency, 911 should be called.)

Examples of illnesses/injuries that may not be life-threatening include, but are not limited to:

- a. Rashes
  - b. Upper respiratory infections
  - c. Sore throats
  - d. Earaches
  - e. Headaches
  - f. Abrasions
  - g. Lacerations
  - h. Flu like symptoms
  - i. Back pain
  - j. Sprains
  - k. Minor fractures
2. The supervisor will provide two (2) copies of the First Report of Injury or illness to the employee to present to the Healthcare Provider and Pharmacy, if needed. The employee must provide the Healthcare Provider with a copy of the completed First Report of Injury or Illness form, which serves as authorization for treatment. The employee's supervisor will ensure that all reports are forwarded to the TPA and Employee Services.
  3. Questions regarding medical treatment and care should be directed to the TPA's managed healthcare company's Case Manager.
  4. The employee must use the authorized Healthcare Provider unless the injury/illness occurred after the Healthcare Provider's hours of operation.
  5. If the injury/illness occurred after the Healthcare Provider's hours of operation, the employee should obtain medical treatment at the nearest urgent care facility/hospital. As soon as possible after treatment, the employee must go to the authorized Workers' Compensation Healthcare Provider as required for continued Workers' Compensation treatment. Questions regarding treatment or prescriptions should be directed to the managed healthcare company's Case Manager.

#### D. Healthcare Provider

Employees covered under Lake County's Workers' Compensation Program must go to the Healthcare Provider authorized by the County, unless the injury/illness requires emergency treatment at an urgent care facility/hospital or the injury/illness occurs after the Healthcare Provider's hours of operation. Specific information such as hours of operation, contact numbers and location can be found on the Employee Services Workers' Compensation webpage. (See *Section F*)

Medical treatment provided by an unauthorized Healthcare Provider may not be covered under the Lake County Workers' Compensation Program.

## E. Workers' Compensation Reports

Workers' Compensation reports are easily obtained from the Lake County intranet, through the "Forms" Quick Link or by going to the Employee Services - Workers' Compensation webpage through the intranet or internet. (See *Section F*)

Supervisors are responsible for ensuring that all reports/forms are provided to the employee(s) and witnesses to complete. Supervisor shall also ensure that all of the documents are completed correctly, collected, and submitted as a complete packet to Employee Services immediately following an incident. (The packet should include the following: First Report of Injury or Illness, Injury/Illness Report – Supervisor Investigation, Injury/Illness Report – Employee Statement, and if needed a Incident Report – Witness Statement.)

1. First Report of Injury or Illness (*Attachment 1*)
  - b. The supervisor and employee must complete the First Report of Injury or Illness immediately (or as soon as possible, if an emergency situation) after an injury/illness is reported.
  - c. The supervisor and employee must complete the report and make two (2) copies to present to the urgent care facility/hospital and pharmacy, if needed. The supervisor shall also provide the employee with a print out of the more specific information and guidance provided on the Employee Services – Workers' Compensation webpage.
  - d. The employee presents a copy of the report to the Urgent Care Facility or Healthcare Provider. This report serves as authorization for treatment. The additional copy of the report serves as authorization for pharmacy/prescription coverage if necessary.
  - e. The supervisor must fax or e-mail the First Report of Injury or Illness report to the County's Workers' Compensation TPA.
  - f. The completed report shall be forwarded to Employee Services, immediately following an incident. (The report should be sent along with the other documents required.)
  - g. This report is required by the state of Florida Department of Financial Services.
2. First Report of Injury or Illness – Report Only (*Attachment 2*)

This report is to be used by supervisors for employees who do not wish to seek medical treatment for the injury/illness, but still need to report the possible Workers' Compensation incident.

- a. Supervisor and employee must complete the First Report of Injury or Illness (Report Only) immediately after an injury/illness is reported.
  - b. Supervisor and employee must complete the Report Only, since the employee elects not to have medical treatment.
  - c. Supervisor must fax or e-mail the report to the TPA.
  - d. The completed report shall be forwarded to Employee Services, immediately following an incident.
  - e. Supervisor should also provide the employee with a copy of the specific information found on the Employee Services - Workers' Compensation webpage. (The report should be sent along with the other documents.)
  - f. This report is required by the state of Florida Department of Financial Services.
3. The Supervisor is responsible for ensuring that the following reports are immediately completed after an injury/illness occurs and/or is reported:
- a. *Required:* Injury/Illness Report – Supervisor Investigation (*Attachment 3*)
  - b. *Required:* Injury/Illness Report – Employee Statement (*Attachment 4*)
  - c. *Required if witness/witnesses:* Incident Report – Witness Statement (*Attachment 5*)

The report(s) shall be forwarded to Employee Services along with the First Report of Injury or Illness, including Report Only.

#### F. Workers' Compensation Webpage

The Employee Services Workers' Compensation webpage provides specific information and contact numbers for the County's Third Party Administrator, Healthcare Provider and Case Manager. Employee Services can also provide this information if necessary.

Supervisors should provide a print out of the specific information found on the Workers' Compensation webpage to the employee along with the First Report of Injury or Illness form. Supervisors should keep copies on hand that can be easily accessible in times of an emergency.

To obtain this information, go to the Employee Services intranet/internet webpage and click on Workers' Compensation in the Wellness & Safety section, and print out the entire page.

#### G. On-the-Job Injury or Illness Flow Chart

The On-the-Job Injury or Illness Flow Chart provides quick reference information on steps to take for emergency medical treatment, non-emergency medical treatment and no medical treatment procedures. (*Attachment 6*)

#### H. Light/Restricted Duty

The supervisor will provide light duty work assignments to any employee on restrictions due to Workers' Compensation Physician recommendations. Light duty work assignments are only provided to employees who experience an on-the-job injury(ies) and/or illness(es).

If the employee's department does not have a light duty work assignment, the supervisor should contact Employee Services. Employee Services will arrange with other departments for light duty assignments.

Employees who refuse light duty work assignments will not receive Workers' Compensation pay, and such employees may use their sick and annual leave, in that order, until released to regular work duty. If the employee has exhausted all accrued leave and still refuses light duty assignments, then the employee will go into a no pay status until the Workers' Compensation Physician releases them to regular work duty. During this time, the employee may have reinstatement rights in accordance with the Family Medical Leave Act (FMLA), if applicable. (See item I. 10.)

The employee will continue light duty work assignment until released by the Workers' Compensation Physician to return to regular work duties. If no light duty assignments exist within the County, the employee shall receive indemnity benefits under the Workers' Compensation program.

#### I. Compensation and Benefits

An employee who is required to be absent from work due to an on-the-job injury/illness shall be compensated as follows:

1. Workers' Compensation does not pay for absences during the initial seven (7) calendar days (cumulative) following an accident. The employee may choose to use accrued sick leave hours for the first 7 days, and as supplement pay to Workers' Compensation pay. Beginning the 8<sup>th</sup> day, the employee will start receiving indemnity benefits of 66⅔% of their average weekly wage. If the absence exceeds 21 calendar days, Workers' Compensation will pay the employee for the initial 7 days.
2. Worker's Compensation will pay compensation benefits for absences beyond the first 7 calendar days in accordance with Florida Statutes Chapter 440.

3. County group benefits (health insurance, life insurance, etc.) shall continue so long as the employee remains in a pay status and in compliance with the eligibility requirements of the County and Workers' Compensation Program. If the employee goes into a no-pay status, the employee will be required to make payments for his/her portion of employee benefits premiums until the employee returns to work Arrangement for payments will be made through Employee Services.
4. All available sick leave hours must be exhausted, before accrued annual leave may be used to supplement Workers' Compensation indemnity benefits. (See item I. 10.)
5. Any leave associated with an on-the-job injury/illness (paid or unpaid), where the injury/illness is a "serious health condition" as defined in the Family and Medical Leave Act, shall be designated as Family Medical Leave (FMLA) and run concurrently with Workers' Compensation leave.
6. Employees are required to report their current work status to their supervisor, as determined by the Workers' Compensation physician (in writing) immediately following each office visit.
7. Different rules apply to employees taking leave in accordance with the Family Medical Leave Act (FMLA). Please refer to the County's FMLA Policy and Procedure for additional information.
8. The employee's time sheet will be coded as follows:
  - a. First day of the on-the-job injury/illness:  
**CW** - Enter the number of hours used spent at the authorized health care facility or urgent care facility. In addition, use CW when employee attends a doctor visit for Workers' Compensation.
  - b. First 7 calendar days of the on-the-job injury/illness:  
**WS** - Enter the number of sick leave hours employee uses.  
**WV** - Enter the number of annual leave hours employee uses.  
**WU** - Enter the number of non-paid hours employee uses.
  - c. After the first 7 calendar days of the on-the-job injury/illness:  
**WR** - Enter 66.6% of employee's work day hours. Employee has the option of supplementing 33.4% with sick or annual leave.  
(e.g., 5.33 **WR** and 2.67 **WS**, for an eight hour day, or 6.66 **WR** and 3.34 **WS**, for a ten hour day.)

- d. When FMLA runs concurrently with Workers' Compensation:
    - FLWR** - After the first 7 calendar days of the on-the-job injury/illness.
    - FLWS** - Enter the number of sick leave /FMLA hours employee uses.
    - FLWV** - Enter the number of annual leave /FMLA hours employee uses
    - FLWU** - Enter the number of non-paid /FMLA hours employee uses.
  - e. When employee is placed on light duty for the on-the-job injury/illness:
    - LD** - Enter the number of hours employee is on light duty.
9. The employee does not use sick leave for Workers' Compensation related doctor's appointments.
10. The County will pay the employee for time taken for medical treatment if it is during their regularly scheduled work hours.

G. Workers' Compensation and Property & Liability Claims Committee

The purpose of the Workers' Compensation and Property & Liability Claims Committee is to review, approve/deny and settle Workers' Compensation, Property and/or Liability claims of \$25,000 or less, and will review and recommend for approval claims greater than \$25,000 to be presented to the Board of County Commissioners for approval. The Workers' Compensation and Property & Liability Claims Committee shall accept or give all proper releases on behalf of the County.

The Board of County Commissioners upon deeming it to be in the best interest of the program to settle a worker's compensation, property or liability claim shall have the authority to do so for claims with a value greater than \$25,000.

H. Safety Action Team

The Safety Action Team will review Injury/Illness reports at monthly meetings and make recommendations to reduce or eliminate future Workers' Compensation claims.

I. Further Investigation

Employee Services may require more information than the Workers' Compensation Reports provide. An investigation may be initiated if Employee Services deems it necessary, if the information contained in the report is contradictory or lacking in detail. The TPA and/or an Employee Services representative will conduct an investigation to gather more information and make recommendations for preventing future claims and possible corrective actions.

**V. RESERVATION OF AUTHORITY**

The authority to issue or revise this Procedure is reserved to the County Manager. The County Manager may authorize exceptions to this procedure when deemed appropriate.

Approved By: Cindy Hall, County Manager  
Date: 7/13/09

**Attachment 1**

**FIRST REPORT OF INJURY OR ILLNESS**

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES  
 DIVISION OF WORKERS' COMPENSATION**  
 For assistance call 1-800-342-1741  
 or contact your local EAO Office  
 Report all deaths within 24 hours  
 1-800-219-8953 or 1-830-922-8953

Received by Claims-Handling Entity	Sent to Division Date	Division Received Date

**PLEASE PRINT OR TYPE**

**EMPLOYEE INFORMATION (Fill in Shaded Areas)**

Name (First, Middle, Last):		Social Security Number:	Date of Accident (Month-Day-Year):	Time of Accident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Home Address: Street/Apt #: City: State: Zip:		Employee's Description of Accident (include Cause of Injury):		
Telephones (Area Code & Number):				
Occupation:				
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Injury/Illness that Occurred:	Part of Body Affected:	

**EMPLOYER INFORMATION (Fill in Shaded Areas)**

Company: Lake County Board of County Commissioners D.B.A.: The Office of Employee Services Street: 315 West Main Street, PO Box 7800 City: Tavares State: Florida Zip: 32778-7800	Federal ID Number (FEIN): 596000695	Date First Reported (Month-Day-Year):
Telephone Number: Area Code & Number 1-352-343-9596	Nature of Business: Governmental	Policy/Member Number:
Employer's Location Address (if different) Street: City: State: Zip: Location # (if applicable):	Date Employed: / /	Paid for Date of Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Accident (Street, City, State, Zip) Street: City: State: Zip: County of Accident:	Last Date Employee Worked: / / Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, give date: / /	Will you continue to pay wages instead of Worker's Comp?: <input type="checkbox"/> Yes <input type="checkbox"/> No Last day wages will be paid instead of Worker's Comp.: / /
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claims containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute §17.234, Section 440.105 (7), F.S.	Date of Death (if applicable): / /	Rate of Pay: \$ Per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Day <input type="checkbox"/> Month
Employee Name Supervisor Name	Agree with description of accident?: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of hours per day: Number of hours per week: Number of days per week:
Name, Address and Telephone of Physician or Hospital Physician: Address: Telephone: Hospital: Authorized by Employer: <input type="checkbox"/> Yes <input type="checkbox"/> No		

**CLAIMS-HANDLING ENTITY INFORMATION**

<input type="checkbox"/> 1. (a) Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 1. (b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached <input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3) <input type="checkbox"/> 3. Lost Time Case - 1st day of disability ____/____/____ Full Salary in lieu of comp? YES Full Salary End Date ____/____/____ Date First Payment Mailed: ____/____/____ AWW _____ Comp. Rate _____ <input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY Penalty Amount Paid in 1st Payment \$ _____ Interest Amount Paid in 1st Payment \$ _____		Employee's 8th Day of Disability: ____/____/____ Entity's Knowledge of 8th Day of Disability: ____/____/____
Remarks:	Insurer Name	
Insurer Code #: 9808	Employee's Class Code:	Employer's NAICS Code: 921190
Service CO/TPA Code #: 6060	Claims-Handling Entity File #:	Insurer Name Claims-Handling Entity Name, Address, & Telephone: <b>Employers Mutual, Inc.</b> 700 Central Parkway Stuart, FL 34994 Tele: 1-800-431-2221 Fax: 1-772-220-1637

**Attachment 2**

**FIRST REPORT OF INJURY OR ILLNESS**  
**\*\*\*\*\*REPORT ONLY\*\*\*\*\***  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**  
 For assistance call 1-800-342-1741  
 or contact your local EAO Office  
 Report all deaths within 24 hours  
 1-800-219-8953 or 1-850-922-8953

Received by Claims-Handling Entity	Sent to Division Date	Division Received Date

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION (Fill in Shaded Areas)

Name (First, Middle, Last):		Social Security Number:	Date of Accident (Month-Day-Year):	Time of Accident: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Home Address: Street/Apt #: City: State: Zip:		Employee's Description of Accident (Include Cause of Injury):		
Telephone (Area Code & Number):				
Occupation:				
Date of Birth: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Injury/Illness that Occurred:		Part of Body Affected:

EMPLOYER INFORMATION (Fill in Shaded Areas)

Company: Lake County Board of County Commissioners D.B.A.: The Office of Employee Services Street: 315 West Main Street, PO Box 7800 City: Tavares State: Florida Zip: 32778-7800		Federal ID Number (FEIN): 596000695	Date First Reported (Month-Day-Year): / /
Telephone Number: Area Code & Number 1-352-343-9596		Nature of Business: Governmental	Policy/Member Number:
Employer's Location Address (if different) Street: City: State: Zip: Location # (if applicable):		Date Employed: / /	Paid for Date of Injury: <input type="checkbox"/> Yes <input type="checkbox"/> No
Place of Accident (Street, City, State, Zip) Street: City: State: Zip: County of Accident:		Last Date Employee Worked: / / Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, give date: / /	Will you continue to pay wages instead of Worker's Comp?: <input type="checkbox"/> Yes <input type="checkbox"/> No Last day wages will be paid instead of Worker's Comp.: / /
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claims containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute §17.234, Section 440.105 (7), F.S.		Date of Death (If applicable): / /	Rate of Pay: \$ Per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Day <input type="checkbox"/> Month
Employee Name Date: / /		Name, Address and Telephone of Physician or Hospital Physician: Address: Telephone: Hospital:	
Supervisor Name Date: / /		Number of hours per day: Number of hours per week: Number of days per week: Authorized by Employer: <input type="checkbox"/> Yes <input type="checkbox"/> No	

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1. (a) Denied Case - DWC-12, Notice of Denial Attached		<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required information in #3	
<input type="checkbox"/> 1. (b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached		Employee's 8th Day of Disability: ____/____/____	
<input type="checkbox"/> 3. Lost Time Case - 1st day of disability ____/____/____		Entity's Knowledge of 8th Day of Disability: ____/____/____	
Date First Payment Mailed: ____/____/____		Full Salary in lieu of comp? YES Full Salary End Date ____/____/____	
AWW _____		Comp. Rate _____	
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. - 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> DEATH <input type="checkbox"/> SETTLEMENT ONLY			
Penalty Amount Paid in 1st Payment \$ _____		Interest Amount Paid in 1st Payment \$ _____	
Remarks:		Insurer Name	
Insurer Code #: 9808		Claims-Handling Entity Name, Address, & Telephone:	
Employee's Class Code:		Employer's NAICS Code: 921190	
Service CO/TPA Code #: 6060		Employer: Mutual, Inc. 700 Central Parkway Stuart, FL 34994 Tele: 1-800-431-2221 Fax: 1-772-226-1637	

**Attachment 3**



**Injury/Illness Report – Supervisor Investigation**

Lake County Board of County Commissioners

Supervisor must complete this report **immediately** following the on-the-job injury/illness.

Report must include **FULL** details concerning the injury/illness incident.

Section I – Employee Information			
Name of Employee	Department	Division	Job Title
Section II – Conditions/Facts			
Date Reported	Time	Location of Incident	Supervisor Name
Division Director Name (If Applicable)		Department Director Name	
Body Part Injured		Nature of Injury / Illness	
<input type="checkbox"/> Head	<input type="checkbox"/> Eye	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Face	<input type="checkbox"/> Ear	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Back	<input type="checkbox"/> Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Chest	<input type="checkbox"/> Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Lungs	<input type="checkbox"/> Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Groin	<input type="checkbox"/> Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Foot	<input type="checkbox"/> Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Ankle	<input type="checkbox"/> Leg	<input type="checkbox"/> Left	<input type="checkbox"/> Right
<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Finger	<input type="checkbox"/> Left	<input type="checkbox"/> Right
		<input type="checkbox"/> Body System	
		<input type="checkbox"/> Abrasion	<input type="checkbox"/> Infectious Disease Exposure
		<input type="checkbox"/> Amputation	<input type="checkbox"/> Toxic Atmosphere Exposure
		<input type="checkbox"/> Strain / Sprain	<input type="checkbox"/> Foreign Body
		<input type="checkbox"/> Bruise	<input type="checkbox"/> Fracture
		<input type="checkbox"/> Burn	<input type="checkbox"/> Hearing Loss
		<input type="checkbox"/> Irritation	<input type="checkbox"/> Unconsciousness
		<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Multiple Injury
		<input type="checkbox"/> Open Wound	<input type="checkbox"/> Heat Stress
		<input type="checkbox"/> Laceration	<input type="checkbox"/> Laceration
		<input type="checkbox"/> Poisonous Plant	<input type="checkbox"/> Puncture
		<input type="checkbox"/> Poisoning	<input type="checkbox"/> Vision Loss
		<input type="checkbox"/> Cold Injury	
		<input type="checkbox"/> Cumulative Trauma	
		<input type="checkbox"/> Heart Attack	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Names of all Witnesses			
Specifically, describe the incident: How it occurred, what task was being done, for how long, with what equipment, at what pace, conditions at the site (e.g., sunny, slippery, indoors, etc.) Identify possible causes or factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) Details are crucial for identifying primary cause of the incident. (If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)			
Supervisor Investigation & Primary Cause of Incident:			
Section III – Preventative Action			
What preventative action will eliminate/minimize the risk of this type of incident again? What would employee do to prevent incident? Examples: Written procedure, training, equipment change, corrective actions-warning/suspension to employee, etc.			
Supervisor Preventative Action:			

Forward completed report to the Office of Employee Services & Quality Improvement, Admin. Building, Rm. 430 / 315  
 W. Main St, Tavares, FL 32778.

**Attachment 4**



**Injury/Illness Report – Employee Statement**

Lake County Board of County Commissioners

Employee must complete this report **immediately** following the on-the-job injury/illness.  
 Report must include **FULL** details concerning the injury/illness incident.

Section I – Employee Information							
Name of Employee			Phone Number			E-mail	
Department			Division			Job Title	
Date	Time	Location of Incident			Supervisor Name		
<b>Body Part Injured</b>				<b>Nature of Injury / Illness</b>			
<input type="checkbox"/> Head	<input type="checkbox"/> Eye	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Abrasion	<input type="checkbox"/> Infectious Disease Exposure	<input type="checkbox"/> Open Wound	<input type="checkbox"/> Heat Stress
<input type="checkbox"/> Face	<input type="checkbox"/> Ear	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Amputation	<input type="checkbox"/> Toxic Atmosphere Exposure	<input type="checkbox"/> Poisonous Bite	<input type="checkbox"/> Laceration
<input type="checkbox"/> Neck	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Strain / Sprain	<input type="checkbox"/> Foreign Body	<input type="checkbox"/> Poisonous Plant	<input type="checkbox"/> Puncture
<input type="checkbox"/> Back	<input type="checkbox"/> Arm	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bruise	<input type="checkbox"/> Fracture	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Vision Loss
<input type="checkbox"/> Chest	<input type="checkbox"/> Elbow	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Burn	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Cold Injury	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Wrist	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Irritation	<input type="checkbox"/> Unconsciousness	<input type="checkbox"/> Cumulative Trauma	
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Hand	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Multiple Injury	<input type="checkbox"/> Heart Attack	
<input type="checkbox"/> Groin	<input type="checkbox"/> Hip	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Other:			
<input type="checkbox"/> Foot	<input type="checkbox"/> Knee	<input type="checkbox"/> Left	<input type="checkbox"/> Right	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
<input type="checkbox"/> Ankle	<input type="checkbox"/> Leg	<input type="checkbox"/> Left	<input type="checkbox"/> Right				
<input type="checkbox"/> Toe(s)	<input type="checkbox"/> Finger	<input type="checkbox"/> Body System					

Section II – Conditions/Facts
<p><b>Specifically, describe the incident:</b> How it occurred, what task was being done, for how long, with what equipment, at what pace, conditions at the site (e.g., sunny, slippery, indoors, etc.) Identify possible causes or factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) Details are crucial for identifying primary cause of the incident. (If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)</p>
<p><b>Employee Statement:</b></p>

Forward completed report to the Office of Employee Services & Quality Improvement, Admin. Building, Rm. 430 / 315  
 W. Main St, Tavares, FL 32778.



**Incident Report – Witness Statement**

*Lake County Board of County Commissioners*

*(This form can be used for workers' compensation and/or property and liability situations.)*

Witness must complete this report **immediately** following the incident.

Report must include **FULL** details concerning the incident.

**Section I – Witness Information**

Name of Witness	Department of Witness	Phone Number of Witness

**Section II – Conditions/Facts**

Name of Employee involved in the Incident	Supervisor of Employee involved in the Incident

Date of Incident	Time of Incident	Specific Location of Incident

**Specifically, describe the incident:** How it occurred, what was our involvement, what was the employee doing (describe task being done), for how long, with what equipment, at what pace, conditions at the incident site (e.g., sunny, slippery, indoors, etc.) Identify possible causes/factors that may have contributed to the incident (e.g., unsafe act, equipment, use of personal protective equipment, etc.) **Details are crucial for processing and prevention.** *(If completing form by hand, please feel free to continue statement on back or attach additional sheets allowing ample room for explanation.)*

**Witness Statement:**

Forward report to the Office of Employee Services & Quality Improvement, Admin. Building, Rm. 430 / 315 W. Main St.  
 Tavares, FL 32778.

**Attachment 6**

