UNIVERSITY of WISCONSIN
GREEN BAY

Worker's Compensation Program

Standard Operating Procedure (SOP)

May 20, 2024

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Guiding Principles

University of Wisconsin-Green Bay (UWGB) has determined a need to develop Standard Operating Procedure (SOP) that provides guidance in managing the University's worker's compensation program and implement UW System Policy #635, Return to Work Policy: Worker's Compensation (UW 635).

To protect and preserve UW System Resources and conscientiously meet UW system responsibilities/

Compliance with this SOP does not eliminate or absolve performance of additional requirements that stem from state or federal laws and policies.

Scope

All departments and employees, faculty, and staff employed within UWGB fall under this SOP.

Locations

The guidelines that are included in this document are applicable to all individuals (students, faculty, staff, contractors, visitors, alumni, parents, etc.) in the UW Green Bay community regardless of their location.

Included Sites in this Plan

- Green Bay Campus (Brown County)
- Manitowoc Campus (Manitowoc County)
- Marinette Campus (Marinette County)
- Sheboygan Campus (Sheboygan County)

Definitions

Employee Capabilities: capabilities and restrictions outlined by a healthcare provider of an injured employee's physical capabilities after a work-related injury. Restrictions and limitations are usually temporary but can also be permanent.

Employee Exposure: employees who are exposed to unsafe elements, such as bloodborne pathogen exposure, asbestos, etc. may need to complete Workers Compensation forms, but the treatment may be covered by Risk Management, not Workers Compensation. Each case is reviewed to make a determination. See also *SOP SRC Reporting*.

Healthcare Provider: A Licensed physician or other medical professional qualified to render medical opinions on the injury in question, providing medically necessary treatment to an employee who sustains a work-related injury.

Modified Work Assignment Supervisor: A supervisor who has been given authority to temporarily supervise an employee who has received a temporary work assignment under the Worker's Compensation Return-to-Work Program.

Return to Work Program: A program implemented to bring an employee back to work after a work-related injury with temporarily modified duties in compliance with restrictions outlined by the employee's treating physician.

Transitional Modified Work Assignment: An offer for a temporary work assignment made to an employee who is recovering from an illness or injury and who has received clearance from a treating healthcare provider to return to work under specific limitations.

Workers Compensation: a benefit program that pays for medical treatment and wages lost due to work-related injuries or illnesses. This benefit overs medical treatment resulting from your work-related injury or illness, lost wages, compensation for permanent disabilities, and/or vocational rehabilitation. UW System provides oversight for this benefit for UWGB.

Roles, Responsibilities, and Reporting

The below table identifies the roles, responsibilities, reporting requirements, and timelines for the Worker's Compensation process. Forms may be viewed in the Appendix of this SOP.

Role	Responsibility	Timeline
Employee	Report any injury, illness, or near-miss injury to assigned Supervisor. Complete the following forms in the event of a work-related injury or illness: ▪ *Employee's Work Injury and Illness Report* ▪ *Employer's First Report**** If medical attention was sought, also complete: ▪ *Authorization to Use or Disclose Health Care Information* ▪ *Voluntary and Informed Consent for Disclose of Health Care Information* Employees are required to understand their responsibilities and impact on leave benefits. Information may be found in What if you are injured at work? In the event a worker's compensation claim is denied, employee will be notified by UW System. Employees may see next steps Department of Workforce Development webpage.	Immediately or within 24-hours
Human Resources	Human Resources does not process Worker Compensation Claims, but does participate in the Return to Work Program.	
Supervisor	Any notice of employee injury or illness, ensure the employee completes their responsible forms. Supervisor should complete: ▪ *Supervisors Accident Analysis and Evaluation* ▪ *Employer's First Report*** When there are situations where employee has an active claim and out for medical, the supervisor must report on employee's report time off for appointments, etc. as sick leave on their timesheets. Once the worker's comp claim is processed, UWSS will update the code within the timesheet and system to be the approved Worker's comp amount and the sick leave will be reinstated.	Within 24-hours of Accident Notification
Supervisor – Modified Work Assignment	Communicate any absences or work conduct to employee's supervisor. Notify Work Comp Coordinator when temporary assignment has been completed.	Immediately

Role	Responsibility	Timeline
Safety Manager	Receive notification from Work Comp Coordinator of an injury and conduct a safety assessment. Complete and forward to UW System Work Comp the *Safety Manager Review Report*. Receive notice of Return-to-Work Program and potential modified work assignment position. Review employee work restrictions and confirm the modified work assignment will suitable for the injury	Within 48-hours of Notification
Work Comp Coordinator	▪ Receive notice of work-related injury or illness. Confirm all required forms have been submitted and entered into UW Claim System. ▪ Upon completion, send notification letter to Employee outlining Worker Compensation process and record the claim on UWGB internal tracking log. For injuries where employee may be out five (5) or more days, Human Resources will be notified to initiate FMLA, if appropriate. Coordinate the Return-to-Work Program if employee has restrictions, and remain in communication with employee, supervisor, and modified work assignment supervisor. Process incoming medical claims from healthcare providers.	**Medical/Incident** as soon as possible (no later than 14 days) **Fatalities**: w/in 12 hours **Lost Time**: w/in 48 hours
US System Worker's Compensation	Notify UWGB Work Comp Coordinator and employee of any additional information required and notification of claim denial.	

**The *Employer's First Report of Injury or Illness* is a required form. However, this form is printed by UW System from the worker compensation claim entry system.

Return to Work Program

UW 635 exists to return injured employees to productive roles in the workforce in a timely manner. This responsibility is shared by management and employees. This program recognizes the value of employee engagement within the organization, the need for continuous productivity, and direct benefit to employees in maintaining their leave bank, reducing absenteeism, and days away from work.

The Return-to-Work Program is coordinated to provide, when available, a Transitional Modified Work Assignment, to employees with work-related injuries with restrictions and limitations identified by a healthcare provider.

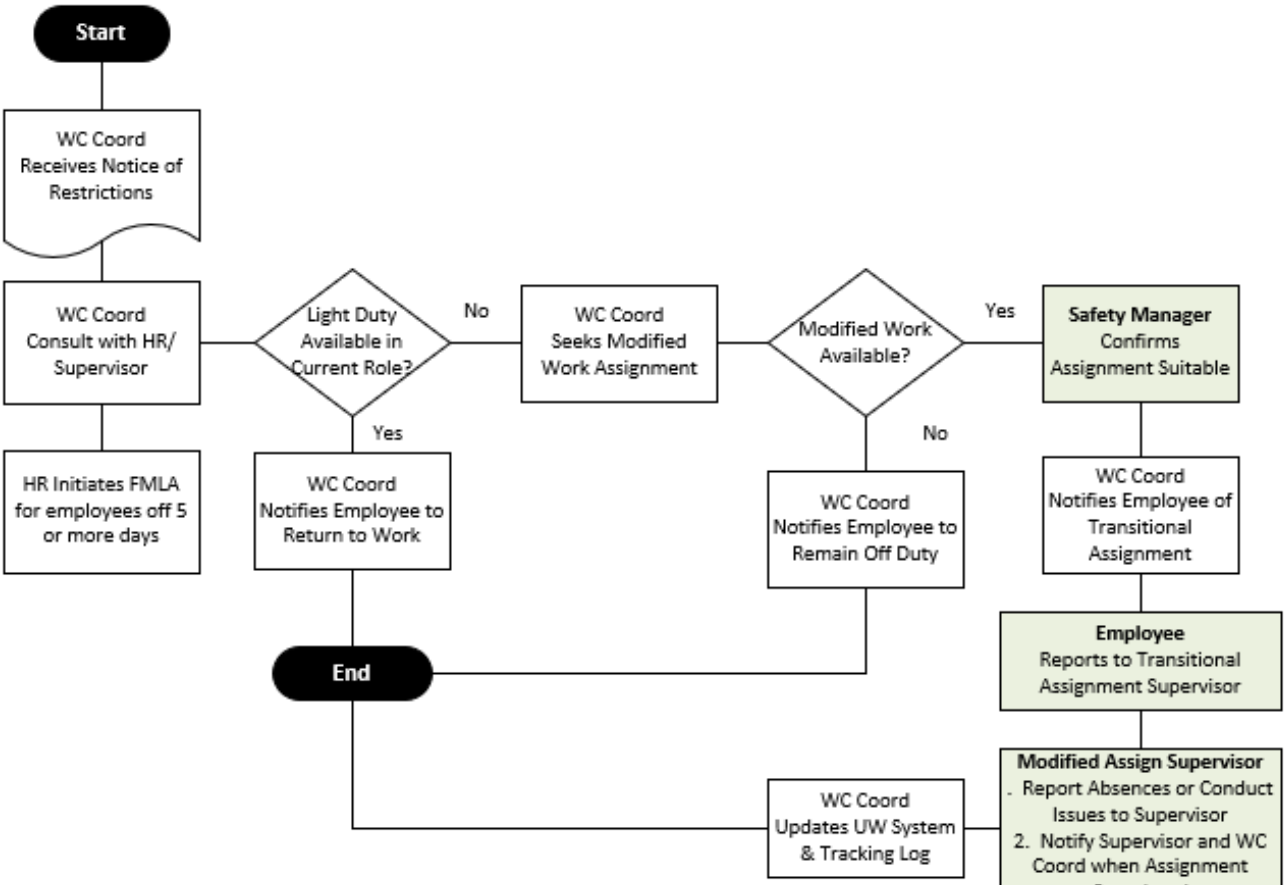
a. Upon receipt of an employee's work restrictions from a health care provider, the Workers' Compensation Coordinator, Human Resources, and current Supervisor will confirm if light duty is available in employee's present role.

   For injuries where employee may be out five (5) or more days, Human Resources will be notified to initiate FMLA, if appropriate.

b. If light duty is not available, the Workers Compensation Coordinator will confirm if other work is available using the Transitional Work Assignment list. The Safety Manager will review to confirm assignment is suitable.

   This temporary placement is outside the scope of the employee's assigned position description and is not necessarily the same number of hours, shift, or work location. The employee's home department will be responsible for the wage and benefit costs during the period of a modified work assignment, regardless of placement.

c. Notification is made to employee to 1) return to work, 2) remain off work, or 3) return to work in a Transitional Work Assignment. Human Resources, Current Supervisor, and Transitional Work Assignment Supervisor are copied on this communication. See *Appendix Return to Work Communication.*



Return to Work Communication Template is used to Communicate to Employee

Transitional Work Assignments

Based on availability, modified work assignments may be available within an employee's home department, or in the areas described below.

Department	Supervisor Contact	Available Jobs	Requirements
Archives	Deb Anderson	Archive Foldering Copying/Scanning Exhibits	Sitting, Repetitive Standing, Limited Work Sitting, Use of Velcro *Potential for restrictive material*
Facility Building & Grounds	As Appropriate	Inventory	Sitting or Walking Lighting Prefer 4-5 x a week, 2-4 hours
Facility Custodians	Jason Willard	Collecting Waste	Bending, Lifting
		Disinfect Surfaces	Walking, Hand Movement
		Lamp Recycling	Chemical training Quarterly, 2-4 hour shift
		Mopping/Dusting Assigned Areas	Standing, Walking Weight restriction, 2-4 hour shift
		SDS Books (2nd Shift Supervisor)	Sitting 2nd Shift Rotation
Facility Mail Room	As Appropriate All 4 campus locations	Inventory	Sitting or Walking Light Lifting Prefer 4-5x a week, 2-4 hours
		Mail Delivery	Walking Light Lifting Prefer 4-5 x a week, 2-4 hours
		Mail Room	Sitting Limited Walking Prefer 4-5x a week, 2-4 hours
Facility Res Life	Julianne Crayton	Grounds Maintenance	Bending, Pulling
		Shop Inventory	Standing Occasional Sitting Pushing/Pulling up to 15 lbs Computer Data Entry
		Student Front Desk	Sitting Occasional Standing Radio/Phone Communications Sporadic with 3-4 hour notice
		Student Mail Room	Sitting Occasional Standing Stretching Sporadic with 3-4 hour notice
Kress Center	Jeff Krueger	Front Desk Coverage	Sitting Need to be trained on system, policies
		Ticket Taking	Sitting Sporadic coverage needs including evening, W/E

Department	Supervisor Contact	Available Jobs	Requirements
Library	Paula Ganyard Erica Grunseth	Dusting Shelves White Board Cleaning Shelf Reading	Hand movements; may require reaching Hand movements; reaching; requires hand and arm mobility Reading books on shelves and verify correct order; requires some training and prefer a longer duration for the modified work assignment, i.e. 3+ weeks.
Student Union	Matt Suwalski	Cleaning Tables Other jobs as available	Downward circular hand motion Holding a spray bottle
Manitowoc / Sheboygan Campus	Jamie Schramm	Miscellaneous Admin Projects	Sitting Potential light computer work
		Fall Semester Assist (helping students find classes)	Walking Campus Layout
		Food Pantry	Standing, Stretching, Lifting
	Gary Van Engen Erik Aleson	See Facility Departments	
Marinette Campus	Executive Officer	Miscellaneous Admin Projects	Sitting May involve lifting boxes
	Grounds Manager Erik Aleson	See Facility Building & Grounds	

Hazardous Duty Benefits

If a University of Wisconsin System **police officer or security officer** suffers injury while in the performance of duties, as defined in the following paragraph, the employee shall continue to be fully paid by the employing institution on the same basis as paid prior to the injury, with no reduction in accrued sick leave, compensatory time for overtime accumulations or vacation and no reduction in the rate of earning sick leave credit or vacation.

Any employee in this category must first complete a Workers Compensation Claim. The Hazardous Duty benefit evolves from a workers compensation claim only when the employee misses work for the injury.

Per UW System Policy 1231 (Hazardous Employment Benefits | UW Policies (wisconsin.edu)), "performance of duties" means duties performed in the line of duty including:

a. In the process of making an arrest or investigating any violation or suspected violation of the law, the quelling of a riot, or any other violence;
b. Engaged in an effort to save lives, recover dead bodies, or protect public or private property;
c. Driving or riding in a vehicle under circumstances which require hazardous maneuvering or speed in excess of the normal or posted limits in the performance of law enforcement duties; or
d. Engaged in authorized public demonstrations or on duty training exercises.

The full pay shall continue while the employee is unable to return to work as the result of the injury or until the employee terminates employment.

The application for benefits process is described in Appendix 1, and the application form is attached as Appendix 2pdf .

Related Documents

University of Wisconsin System Policy #635 Return to Work: Workers Compensation
University of Wisconsin-Green Bay Workplace Safety Policy HR-14-16-2
University of Wisconsin-Green Bay Workplace Conduct Policy HR 14-16-6
UW System Policy #1231 Hazardous Duty Benefits

Reference: Forms

As described within this SOP, Worker Compensation forms required for processing worker compensation claims are described below. These forms may also be found on the Risk Management Forms webpage or on the attached pages.

UNIVERSITY of WISCONSIN
GREEN BAY

Employee's Work Injury and Illness Report

State of Wisconsin
University Of Wisconsin System
UW-
UWS/ORM-1Emp (11/14)

EMPLOYEE'S WORK
INJURY AND ILLNESS REPORT

FOR AGENCY USE ONLY
Claim Number
Claim Examiner / Representative

Please Type or Print
INSTRUCTIONS:
1. **Complete within 24 hours of the injury.**
2. **Sign and date the completed report**
3. **Submit to your supervisor to complete the WKC-12 form.**
4. **Direct any questions to your agency Worker's Compensation Coordinator.**

Employee Name (as it appears on payroll)		Time of Injury AM ☐ PM ☐	Date of Injury
Work Telephone ( )	Home Telephone ( )	Social Security Number * XXX-XX-	
Was Medical Treatment Required? ☐ Yes ☐ No First aid only ☐ Yes ☐ No Time Lost From Work ☐ Yes ☐ No Last day worked (MM/DD/YY)		Name and Address of Treating Practitioner/Facility	
Exact location of where accident took place (inside, outside, building name, room, vehicle, etc.)			
Witnesses (names, addresses, work telephone numbers)			
Describe in detail what you were doing when the injury /illness occurred. How exactly did it happen?			
Date the injury / illness reported to my supervisor (Month, Day, Year)			

Part of body injured (Check ***ALL*** that apply, and circle appropriate position) (Thumb = Finger 1, Great toe = Toe 1)

☐	Abdomen	☐	Back U M L	☐	Finger R L 1 2 3 4 5	☐	Head	☐	Mouth	☐	Shoulder R L
☐	Ankle R L	☐	Eye R L	☐	Foot R L	☐	Knee R L	☐	Neck	☐	Toe R L 1 2 3 4 5
☐	Arm R L	☐	Elbow R L	☐	Hand R L	☐	Leg R L	☐	Nose	☐	Wrist R L
☐	Other (Please specify)						For Hand and Arm injuries circle your dominant arm : Right Left				

Have you ever been treated for a similar injury or condition? ☐ Yes ☐ No	If Yes Date(s) of Treatment	Name of Practitioner, Hospital or Clinic Which Provided Prior Treatment for Similar Injury:

Please read carefully. I certify that the above statements are true and accurate and I understand that a false worker's compensation claim is a violation of Wisconsin criminal code, which may result in a fine, imprisonment, or termination from employment. Further I understand that the signature below authorizes medical, mental health and chiropractic providers to release all medical, mental health and chiropractic records to the State of Wisconsin, University Of Wisconsin System, Office of Risk Management, Worker's Compensation Department, or its designated representatives, at 780 Regent St., Madison, WI 53715-2635.

Employee Signature _____ **Date** _____

FOR AGENCY USE ONLY	PRIMARY ORGANIZATION CODE	FUND NUMBER	%
	1-285-0___-_____-_____		
	SECONDARY ORGANIZATION CODE	FUND NUMBER	%
	1-285-0___-_____-_____		

LOSS DESCRIPTION CODES	CAUSE / OCCURRENCE	OBJECT	RESULT	LOCATION	OCCUPATION
	___ ___	___ ___	___ ___	___ ___	___ ___

OSHA CODES	Incident was OSHA "recordable"? ☐ Yes ☐ No	
Name of Authorized Representative		Date

*Your Social Security Number must be provided and will be used for positive identification in the processing of any claims.

UNIVERSITY of WISCONSIN
GREEN BAY

Employer's First Report of Injury or Disease

Is not required to be filled out by employee or supervisor. This form will be automatically generated by UW System.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to (608) 267-0394.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(Please read the instructions on page 2 for completing this form)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number XXX-XX -	Sex ☐ M ☐ F	Employee Home Telephone No. ( ) -

Employee Street Address	City	State	Zip Code -	Occupation

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured? ☐ Yes ☐ No	Nature of Business (Specific Product)

Employer Mailing Address	City	State	Zip Code -	Employer FEIN -

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN -

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN -

WAGE INFORMATION

Wage at Time of Injury $	Specify per hr., wk., mo., yr., etc. Per:	In Addition to Wages, Check Box(es) If Employee Received: ☐ Meals ☐ Room ☐ Tips	No. of Meals/wk. No. of Days/wk Avg. Weekly Amt. $

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? Yes No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury : AM : PM	Last Day Worked	Date Employer Notified	☐ Date Returned to Work ☐ Estimated Date of Return

Did Injury Cause Death? ☐ Yes ☐ No	Date of Death	Was This a Lost Time or Other Compensable Injury? ☐ Yes ☐ No	Did Injury Occur Because of: ☐ Substance Abuse ☐ Failure to Use Safety Devices ☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? Yes No Was Employee Hospitalized Overnight as an In-Patient? Yes No
Name and Address of Treating Practitioner and Hospital:
Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number ( ) -	Position	Date Signed

WKC-12 (R. 10/2016) **SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT**

UNIVERSITY of WISCONSIN
GREEN BAY

Supervisor's Accident Analysis and Prevention Report

State of Wisconsin
University of Wisconsin System
UW-System
UWS/OSLP-2 (2/98)

SUPERVISOR'S ACCIDENT ANALYSIS AND PREVENTION REPORT

SUPERVISOR'S REPORT

INSTRUCTIONS:
1. **Within 24 hours of notice of the accident, complete this report.**
2. **Send report to the Worker's Compensation Coordinator.**
3. **If you were not present at the time of injury, interview the employee.**

Employee Name	Social Security Number Job Classification
Department Name and Location Work Unit	
Date of Accident / / Time of Accident	Date injury reported / /

ACCIDENT DESCRIPTIONS: From your analysis, describe in detail the action, occurrence or event that resulted in the accident. Identify the exact location where the accident took place: ***Repetitive activities, lifting or material handling***, exposure to chemicals, push/pull or slip and fall, etc. If equipment related, was it defective? Could it be modified to prevent further injuries? Were safety procedures followed? Have employe's job duties changed recently? If so please explain.

Safety devices or other equipment in use at time of accident:

What action could be taken to prevent a similar accident?

Do you agree with the employee's account of the accident? ☐ Yes ☐ No If NO, Please explain.

Has the employee ever reported any previous physical condition(s) associated with work or non-work activities (second job, sports, etc. that could be related to or aggravated by this injury/illness? ☐ Yes ☐ No If YES, please explain

Supervisor's Name (Please Print)	Date
Title	Phone # ( )

If injury involved repetitive motion or material handling, Supervisor must complete reverse side

Safety Manager's Review

UNIVERSITY of WISCONSIN GREEN BAY	SAFETY MANAGER'S REVIEW	
	Claim Number:	
	Employee Name:	
	Date of Accident:	

INSTRUCTIONS FOR SAFETY MANAGERS:
1. Complete the Safety Manager's Review within 48 hours of being notified of an incident. Conduct an investigation by interviewing the employee and supervisor and seek signed witness statements. Visit the scene of the incident and include photos pertinent to the incident.
2. Submit form to the Worker's Comp Coordinator & provide a copy to the employee's supervisor with corrective action recommendations.

Was your analysis / review of this accident based on (please check all that apply:

Interview with:	☐ Employee's Supervisor ☐ Injured employee ☐ Witness	Phone call with:	☐ Employee's Supervisor ☐ Injured employee ☐ Witness	☒ Paper Review ☐ Other:

1. Describe the incident based on your investigation: (how and why it happened, where it happened, who was involved, and who did you interview).

2. What was the primary cause of the incident?

3. What corrective action(s) will be taken to prevent a similar accident in the future?

Safety Manager signature:	**Phone number:**	**Date:**

UNIVERSITY of WISCONSIN
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Employee Authorization to Use or Disclose Health Information

UNIVERSITY OF WISCONSIN SYSTEM
OFFICE OF RISK MANAGEMENT
WORKER'S COMPENSATION PROGRAM

Authorization to Use or Disclose Health Information to Worker's Compensation Self-Insurer

Injured Employee:

Worker's Compensation Claim Number:

Date of Birth:

Authorization Expiration Date: **UNTIL WORKER'S COMPENSATION CASE IS CLOSED.**

1. I authorize the release of medical information created prior and after the date of my signature to University of Wisconsin System or their representatives at the State of Wisconsin.

2. I authorize any health care providers/physicians/ psychologists/psychiatrists to provide record copies.

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to my Worker's Compensation self-insurer, the University of Wisconsin.

5. This information for which I'm authorizing disclosure will be used for management of my worker's compensation claim.

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the University of Wisconsin System. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my Worker's Compensation self-insurer, the University of Wisconsin System, when the law provides the System with the right to contest a claim.

7. I understand that by claiming worker's compensation I waive the usual practitioner-patient privilege and my personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal privacy laws or regulations. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter of their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.

8. I understand that the health care provider may not condition my treatment, payment, enrollment or eligibility of benefits on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purposes of creating protected health information for disclosure to a third party.

9. This consent or photostatic copy of this authorization shall be as valid and effective as the original.

Signing this document will expedite the investigation of your claim and consideration of your receiving benefits. You may refuse to sign this document. However, this could delay the investigation of your claim, and may result in suspension of worker's compensation benefits.

_____ _____
Signature of injured employee or legal representative Authorization Date

_____
(If signed by legal representative, relationship to employee)

7/30/2013

UNIVERSITY of WISCONSIN
GREEN BAY

MEDICAL PROVIDER LIST

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

MEDICAL PROVIDER NAME_____

CLINIC NAME_____

ADDRESS_____

PHONE NUMBER_____

TREATMENT DATES_____

PLEASE USE THE BACK SIDE OF THIS FORM OR ANOTHER PIECE OF PAPER FOR ADDITIONAL MEDICAL PROVIDERS.

Return Forms To: **University of Wisconsin System Administration**
Office of Risk Management
780 Regent St.
Madison, WI 53715-2635

UNIVERSITY of WISCONSIN
GREEN BAY

Employee Voluntary and Informed Consent Disclosure

Voluntary and Informed Consent for Disclosure of Health Care Information

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

UNIVERSITY OF WISCONSIN SYSTEM

Office of Risk Management

780 Regent Street
Madison, Wisconsin 53715-2635
(608) 890-4792 Risk Management/Worker's Compensat
(608) 262-4792 Occupational Safety and Health
(608) 262-5252 Environmental Affairs
(608) 263-7330 Fax
website: http://www.wisconsin.edu/wc

By law, all health care providers must provide to any employee, employer, worker's compensation insurer or their representative any information reasonably related to any alleged work injury. However, determining the relationship of prior medical records to a work injury can be difficult and time-consuming. Therefore, to assist in the timely investigation of your claim, this document authorizes the health care provider to release medical information without attempting to determine the extent of its relationship to your alleged work injury.

You are not required to sign this document. You may refuse to sign this document without jeopardizing your right to collect worker's compensation benefits. However, by assisting in the investigation of your claim, you are likely to receive benefits quicker than if you refuse to authorize the release of medical information.

Health Care Facility Name		Street Address	
P.O. Box	City	State	Zip Code
Patient (Employee) Name		Employer Name	
Patient Birth Date		WC Claim No.	

The patient named above hereby authorizes the health care provider named above to disclose all records checked below in its possession relating to the patient's health, treatment and evaluation to:

Name and Address of Party Authorized to Receive Protected Information
UW SYSTEM ADMINISTRATION, OFFICE OF RISK MANAGEMENT
780 REGENT ST, MADISON, WI 53715-2635

or its designated representatives, and to furnish to them a legible, certified duplicate of all records, writings, reports, test results and x-rays in its possession containing such information. This authorization includes *all* records, reports, correspondence, or other materials in the possession of the health care provider authorized, even if those materials were not generated by the health care provider, and the redisclosure of such materials is hereby authorized. This release is for use in the investigation, preparation, evaluation, and/or hearing of the worker's compensation claim described above.

CHECK ONE:

☐ **A.** **Physical Only**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical health, treatment and evaluation including, but not limited to, any made or provided by any physician, nurse, chiropractor, osteopath, dentist, physical therapist, hospital, or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited to Wis. Stat. §§ 146.81 and 146.82, and 45 C.F.R. § 164.508.

☐ **B.** **Physical and Other**. Release all records, correspondence, and any other information from whatever source regarding the patient's physical and mental health, drug and alcohol abuse, HIV and AIDS tests, treatment, and evaluation including, but not limited to, any made or provided by any physician, psychiatrist, psychologist, nurse, chiropractor, osteopath, dentist, physical therapist, hospital or any other health care provider.

This consent constitutes a waiver of any privilege created by state or federal statute, regulation, rule or other authority, including but not limited Wis. Stat. §§ 51.30, 146.025, 146.81 and 146.82, 42 C.F.R., Chap. 1, subpart C, § 2.31 and 45 C.F.R. § 164.508.

Patient Signature (or Person Authorized to Sign for Patient) — for Option B:

Patient Signature (or Person Authorized to Sign for Patient):	Date:

UNIVERSITY of WISCONSIN
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In signing this consent form, I acknowledge that I understand that:

- I am authorizing release of the records and information listed above.
- I am waiving any privilege that may otherwise prevent disclosure of the records and information listed above.
- I understand that the health care provider named above, whom I am authorizing to disclose my protected health information, may not condition my treatment, payment, enrollment or eligibility for benefits (if applicable) on whether I sign this authorization, except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.
- I may revoke this authorization at any time by a written request to the party authorized above to receive information, except that the party authorized above to receive such information may rely upon any personal health information received before the revocation of this authorization.
- I may obtain a copy of the disclosed records and information, upon written request to the party authorized above to receive information.
- My personal health information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by federal law. My personal health information may be released to any of the following: the employer, the worker's compensation insurer, the Department of Workforce Development, other parties to this matter or their attorneys; the Labor and Industry Review Commission; any court on any action or proceeding relating to this matter; experts retained or consulted by any party; and any of their agents, employees, or representatives. I specifically authorize and consent to any such disclosure and redisclosure.
- I am entitled to a copy of this consent form after I sign it.

If you have any questions about this document, you should contact the Worker's Compensation Division at (608) 266-1340. You should not sign this document if the name of the health care provider is blank.

This consent is subject to revocation at any time. If not revoked, this consent is effective for two (2) years from date signed. This authorization expressly waives any requirement that it must be used within a certain number of days after the date of signing, or that it must be dated within any time period before the date it is used. This authorization shall also extend to records of future treatment, after the date of signing of this authorization, as long as such treatment occurs while this authorization is still in effect. A photocopy copy shall be as valid as the original.

Patient Signature (or Person Authorized to Sign for Patient):	Date:
If not signed by patient, authority/designation to sign is based on the fact that the patient is: ☐ A minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other:	

UNIVERSITY of WISCONSIN
GREEN BAY

Reference: Initial Workers Compensation Communication

TO: Insert

FROM: Sandi Maine-Delepierre

DATE: May 26, 2022

RE: Workers Compensation Injury Reporting

Thank you for reporting your injury at work to your supervisor and I hope you are doing well! Please follow these steps if you haven't already done so.

1. Complete the following worker's compensation forms:

Employee's Work Injury and Illness Form	Employee Work Injury and Illness Report Please be sure to be specific as to the location of the physical injury (e.g. Right Foot).
Supervisor's Accident Analysis Form	Your Supervisor completes this form. Supervisor's Accident Analysis and Prevention Report

2. Please submit your completed paperwork using one of these methods:
   - **Email** to maines@uwgb.edu (If you email the forms, please remove your social security number first.)
   - Send to CL 722 via intercampus mail Attn: Sandi Maine-Delepierre
   - Drop off in the Business and Finance Office (CL722)

3. Review this webpage for important worker's compensation information: https://www.wisconsin.edu/workers-compensation/employees/.

4. If you need medical attention related to your injury, please let the medical provider know that this is a work-related injury, and provide them the following information so the bills are processed correctly:
   WC Claim Number: (TBD)
   Insurer: UWSA Office of Risk Management (self-insured)
   Billing Address: 780 Regent St, Madison, WI 53715
   Billing Fax: 608-263-7330
   Adjuster phone number: 608-890-4792
   Email: workcomp@uwsa.edu

5. If you have time off of work related to your injury (ex. recovering, attending doctor appointment), please let me know. You would need to indicate on your timesheet or leave request the time lost for the injury. Please use sick leave or vacation and write "WC" in the comments field.

   If entering the paid leave on your timesheet, add the comment by clicking on the conversation bubble on the left side of that row, and enter the comment. If you are taking two hours off to attend a physical therapy appointment, for example, you could enter "WC – PT appt 2 hrs".

   If you are taking a full day off and have one hour for a doctor appointment and taking vacation the rest of the day, you could enter "WC 1 hr & Vacation 7 hrs".

Reference: Return to Work Communication

TO: Insert

FROM: Sandi Maine-Delepierre

DATE: May 26, 2022

RE: Workers Compensation Injury – Return to Work Program

You are receiving this communication as you have recently been injured while performing the duties of your job description. Your provider has notified the University that the injuries sustained will require restrictions to your job duties as follows:

- Insert Restrictions

You are instructed to:

	Remain off-duty. Your restrictions cannot be accommodated at this time. You are expected to follow your provider instructions and remain in communication with your Supervisor.

	Return to Work. Your Supervisor is able to accommodate your restrictions.

	Return to a Transitional Modified Work Assignment. We recognize the value you provide to our organization and your team. To provide full employee engagement, a Transitional Modified Work Assignment has been assigned to you. Your home department will be responsible for your wage and benefit costs during this period. You are required to report to the temporary supervisor and work location noted below. Your Temporary Supervisor will provide you with additional details for this temporary work assignment.

Temporary Supervisor Name	
Contact Email/Phone	
Building	
Start Date	
Start Time	
Other Notes	

Please do not hesitate to reach out to myself or your Supervisor for any questions. We are here to ensure your Transitional Work Assignment is successful.

cc: Temporary Supervisor
Current Supervisor
Kimberly Deering, HR