# COUNTY OF KENOSHA

## EMPLOYEE WORK INJURY FORM

Division of Human Resources
1010 - 56th Street
Kenosha, WI 53140
(262) 653-2800

## SECTION 1: EMPLOYEE STATEMENT OF WORK-RELATED INJURY

Full Legal NAME________________________________________________

Home Address________________________________ City & State ______________________

Work Phone ____________________ Home Phone ____________________ Cell Phone ____________________

Job Title ______________________________ Department/Division ______________________

Who is your Supervisor? ______________________ Supervisor's Office Phone________________

**DATE of INJURY** or Onset of Work-Related Illness ______________________________

What was your wage at time of injury? ____________________Are you ☐ Full Time OR ☐ Part Time

What is your normal start time? ____________________ What time did you actually begin work? ____________________

What time did the accident / injury occur? ______________________________

Did the accident / injury occur ☐ before ☐ during or ☐ after the work shift? (Please check the box that applies)

What were you doing just before the accident / injury occurred? ______________________________

______________________________________________________________

What happened / how did the injury or work-related illness occur? ______________________________

______________________________________________________________

______________________________________________________________

What is the injury or illness? (Please be specific in your description of the injury or illness and identify the body part affected)_____

______________________________________________________________

______________________________________________________________

What object or substance directly harmed you? (Leave blank if this does not apply to the incident) ____________________

______________________________________________________________

Witnesses to the accident / injury ______________________________

**IF YOU SEEK MEDICAL CARE OR MISS TIME FORM WORK DUE TO THIS INJURY/ILLNESS:** You must also have your physician complete page 2. It is your responsibility to submit the completed page 2 directly to your supervisor.

UNPAID WAITING PERIOD: Statutory Worker's Compensation Temporary Total Disability benefits (lost wages) do NOT cover your first three (3) missed working days. Please indicate below how we should charge your time (unless you fall under the Non-Classified pay plan or a collective bargaining agreement that provides coverage for this waiting period). CHECK ONE BOX ONLY:

Remain ☐ UNPAID or charge my ☐ CASUAL ☐ VACATION ☐ PAID-TIME-OFF

I agree to NOTIFY my supervisor of any work restrictions/limitations, anticipated time off work including projected return to work date, and updates to these as they change. I also agree to submit to nurse case management and/or independent medical evaluation(s) conducted by an independent health care professional as deemed necessary by your worker's compensation representative.

Employee Signature ______________________________ Date ____________________

******SUBMIT THIS COMPLETED FORM DIRECTLY TO YOUR SUPERVISOR*******

## SECTION 2: SUPERVISOR

Upon receipt: Fax this form directly to Wisconsin Municipal Mutual Insurance Company (WMMIC) at **FAX (608) 852-8647**
Upon seeking medical care Employees are required to have Page 2 completed and returned to supervision. Upon receipt of a completed Page 2 fax to WMMIC. The original or copy (fax) of these forms must be forwarded to your department's office manager or individual responsible for approving your payroll for further processing and filing.

Supervisor Signature ______________________________ Date ____________________

# COUNTY OF KENOSHA

## WORKER'S COMPENSATION CLAIM FORM

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## SECTION 3: PHYSICIAN'S STATEMENT

**This form is required to determine wage benefit eligibility for Kenosha County employees. Please note that KENOSHA COUNTY ATTEMPTS TO ACCOMMODATE MEDICAL RESTRICTIONS WHENEVER POSSIBLE INCLUDING TEMPORARY REASSIGNMENTS TO SEDENTARY WORK. This form is your certification that our employee is temporarily totally disabled or is able to return to work with clearly defined physical limitations or to unrestricted full duty. We appreciate your time in completing this form in its entirety.**

1) Patient/Employee Name____________________
2) Did the injury or illness arise out of the employee's employment? ☐ Yes ☐ No
3) Date of work-related injury or onset of work-related illness ____________________
4) Did the work-related injury occur as the result of a traumatic accident? ☐ Yes ☐ No
5) Diagnosis____________________
6) Description of Injury or Illness ____________________
7) Was the patient/employee treated in an Emergency Room? ☐ Yes ☐ No
8) Hospitalized as an In-Patient? ☐ Yes ☐ No
9) WORK STATUS (Check one):

   ☐ **NO WORK** (Temporary Total Disability): **Please Provide PROJECTED RTW Date**: ____________________

   ☐ **LIGHT/RESTRICTED DUTY: Please Provide PROJECTED RTW Date**: ____________________

   **RESTRICTIONS** (Please provide detailed physical/psychological limitations) ____________________

   ☐ **FULL DUTY (Unrestricted): RETURN TO WORK DATE:** ____________________

10) Next Appointment Date____________________

11) Attending physician (please print) ____________________

    Attending physician's address ____________________ City & State____________________

    Physician's office phone number ____________________

    Attending physician's signature____________________ Date ____________________

**Please return this completed form to your patient (our employee) for submission to their supervisor.**