COUNTY OF KENOSHA

EMPLOYEE ACCIDENT & SICKNESS FORM

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

SECTION 1: EMPLOYEE INFORMATION & STATEMENT OF ACCIDENT/SICKNESS (A&S)

INSTRUCTION: Do not use this form to document a work-related injury or claim worker's compensation benefits. THIS FORM MAY BE USED TO CLAIM BENEFITS UNDER THE COUNTY'S ACCIDENT & SICKNESS (A&S) PAY MAINTENANCE PLAN. Complete and sign Section 1. Have your doctor complete and sign Section 2. Then, deliver this completed form to the Human Resources Office located at the County Administration Building, 1010 56th Street, OR via Confidential

FAX to (262) 653-2463

It is your responsibility to ensure Human Resources receives your claim form.

DO NOT USE THIS FORM FOR WORKER'S COMPENSATION RELATED INJURIES/ILLNESSES

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 Illness (first calendar day of disability) _____

What was the First Day you missed work? _____

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

_____

_____

_____

If the disability is the result of an accident/injury please describe what happened: _____

_____

_____

_____

UNPAID WAITING PERIOD: Paid Accident & Sickness benefits do NOT cover your first three (3) missed working days. If this A&S leave also qualifies for State Family and Medical Leave benefits, then 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 will keep my supervisor apprised of changes in my work status. 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 the County.

Employee Signature _____ Date _____

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SECTION 2: 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.

DO NOT USE THIS FORM FOR WORKER'S COMPENSATION RELATED INJURIES/ILLNESSES

1) Patient/Employee Name_____

2) Date employee became medically disabled from work (**1st calendar day of disability**) _____

3) Description of Injury or Illness _____

_____

4) Diagnosis_____

_____

5) Did the injury occur as the result of a traumatic accident/injury? ☐ Yes ☐ No

6) Does this injury/illness require out-patient surgery (as defined by the agency for healthcare research & quality)? ☐ Yes ☐ No

If yes, date surgery performed? _____

Please describe the surgical procedure: _____

7) Hospitalized as an In-Patient? ☐ Yes ☐ No Date Hospitalized: _____Which hospital? _____

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_____

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) or Confidential FAX to (262) 653-2463