

What to do if someone is injured at work



Get medical care and report the injury

■ If it's an emergency, call 911 or get the employee to the nearest emergency facility immediately.

If the employee needs non-emergency medical treatment	OR	If you're unsure whether the employee needs medical treatment
<p>Preferred clinic:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <ul style="list-style-type: none"> If you do not have a preferred clinic you can look for a nearby occupational medicine or high-quality primary care clinic. Report the injury online at sfmic.com/report or by phone at (855) 675-3501 (choose the report-only option during business hours) 		<p>Policy number:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>(This may be needed for identification purposes when you call the hotline)</p> <ul style="list-style-type: none"> Call (855) 675-3501 together with the employee and choose the nurse option. The employee will get a treatment recommendation from a nurse, and SFM will receive the First Report of Injury.

Please note: In most states the employee has the right to choose where to seek treatment, but in Iowa employers can choose the medical provider.

☐ **Send the following forms with the employee on doctor visits:** [Insurance ID card](#), [work-ability form](#), [employer letter to treating physician regarding return to work](#).

Follow up on the injury

- ☐ Give the injured worker the "[What to expect if you've been injured at work](#)" brochure
- ☐ Complete the [accident analysis form](#), or your established review process
- ☐ If the employee is off work due to the injury, stay in contact and provide the [Return-to-work expectations letter](#) for employees
- ☐ Bring the employee back to work as soon possible by offering light-duty work

If you have questions, you can contact the following members of your SFM team for help at (800) 937-1181:

To print or download a copy of this packet, or any of the resources inside visit sfmic.com/resources



WORKERS' COMPENSATION

Insurance identification form




This form identifies SFM as your insurer for the work injury, and gives medical providers information on where to send bills.

Empleado: Este formulario identifica a SFM como su aseguradora para la lesión laboral y les brinda a los proveedores médicos información sobre dónde enviar las facturas.

Entregue este formulario a su proveedor de atención médica.

Employer: Please fill out the information below and give this sheet to your employee to take along on medical visits. Make sure the date of injury matches the date on the First Report of Injury.

Employee: Please give this form to your health care provider.

Cut around dotted line		Fold
<div><div>SFM <small>The Work Comp Experts</small></div><div>Insurance identification information</div></div> <div>Employee: _____</div> <div>Date of birth: _____</div> <div>Date of injury: _____</div> <div>Employer: _____</div> <div>Policyholder number: _____</div> <div>Claim number: _____</div> <div>Employer contact: _____</div> <div>Contact phone number: _____</div>	<div>Send medical bills and records:</div> <div><div> Electronically through Jopari Solutions using payer ID J1553 (Visit jopari.com or call (866) 269-0554 to sign up or learn more)</div><div><div> By mail to SFM Companies P.O. Box 9416 Minneapolis, MN 55440</div><div>Payment will be provided according to the state's workers' compensation treatment parameters and payment rules for accepted workers' compensation claims. Call SFM for authorization on all surgeries, medical imaging, durable medical equipment and any treatment that departs from the state's treatment guidelines.</div><div>(800) 937-1181 sfmic.com</div></div></div>	Fold

Contact SFM at (952) 838-4200 or (800) 937-1181 or through sfmic.com.

WORK ABILITY/ RETURN-TO-WORK



Send itemized medical billings and records to:
SFM Companies, PO Box 9416, Mpls, MN 55440
Fax: (952) 838-2000 Phone: (800) 937-1181

Send this completed form with the employee.

EMPLOYEE	HEIGHT	WEIGHT	DATE OF BIRTH
EMPLOYER	DATE OF INJURY/ILLNESS		

DIAGNOSIS	ICD-10 CODE
-----------	-------------

History, mechanism of injury, and findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes, _____%

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached _____

RETURN TO WORK

☐ Return to work with **no limitations** on _____/_____/_____
MO DAY YR

☐ Return to work **with limitations** on _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

_____ has light-duty work available. Please call _____ at () _____ if you plan to take this employee off work.

☐ Unable to work from _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

EMPLOYEE'S CAPABILITIES

BODY PART AFFECTED: ☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot

☐ Other _____

SIDE AFFECTED: ☐ Left ☐ Right ☐ Both

	Not at all	Rare	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%		Not at all	Rare	Occasional 0-33%	Frequent 34-66%	Continuous 67-100%	Comments
Lift/Carry						Hand, wrist and shoulder activities						
0-9 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid prolonged, repetitive or forceful:						
10-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gripping/grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20-29 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive						
30-39 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wrist motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40-49 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reaching:						
No lift from floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						At shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						Below shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Push/Pull without resistance						Restrictions (circle):						
0-19 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keyboarding (hrs/shift)	0	1-2	3-4	5-6	7	
20-40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing (hrs/shift)	0	1-2	3-4	5-6	7	
> 40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Total spread out evenly over shift at _____ intervals						
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change positions every						
Twist/turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> As needed						
Kneel/squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Half hour						
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> One hour						
Stand/walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Two hours						
Ladder/stair climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Worksite stretches, i.e., per handout						
						<input type="checkbox"/> Exercises <input type="checkbox"/> Other _____						

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every _____

☐ Medication _____

☐ Ice _____ min. _____ ☐ Heat _____ min. _____

☐ Splint/brace _____

☐ Referral _____

Follow-up appointment scheduled for _____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

CLINIC	CLINIC ADDRESS	LICENSE / REGIS.#	DATE OF EXAM
HEALTH CARE PROVIDER NAME (PRINTED)	HEALTH CARE PROVIDER SIGNATURE	PHONE	FAX

ATTENTION PHYSICIANS:

Your patient's employer offers transitional, light-duty work. Please contact the employer if you plan to take this employee off work.

Please complete the form on the back of this sheet, or a similar form, to document any work restrictions.

Letter to the treating physician

Medical provider/clinic name

Medical provider/clinic address

Medical provider/clinic city, state and zip code

Employee name:

Employee date of birth:

Dear Physician,

Our organization provides alternate duty work to its employees who become injured. We strive to return injured employees to work as soon as they are medically able, and within their medical restrictions, with the goal of helping them heal and return to their regular jobs.

Current positions can be modified to accommodate the medical limitations of injured employees by altering specific tasks, reducing work hours or modifying workstations and equipment. If this is not possible, we'll make transitional jobs available elsewhere within the company.

If medical restrictions are appropriate for the employee above who you are treating, and if you have any questions about the modified work to accommodate those restrictions, please call _____ at _____.

Contact name

Contact phone number

In order to help facilitate a smooth and safe return to work, please complete the attached Work Ability and Return to Work form or a similar document.

Thank you for working with us to help our employees return to work.

Sincerely,

Your name

Your title and organization/company name



When medical restrictions prevent injured employees from doing their regular jobs, you can bring them back to work by providing modified-duty or light-duty jobs.

Modified-duty jobs

Consider whether current positions could be modified to fit medical restrictions by:

- Adjusting workstations
- Altering specific tasks

Light-duty jobs

Otherwise, look for a temporary transitional job that falls within medical restrictions. The following list provides some examples:

General industry

- Call for Safety Data Sheets
- Filing, copying
- Shredding
- Data entry
- Phones (customer contact)
- Training
- Proof paperwork
- Preventive maintenance
- Driving
- Audit for HazCom compliance
- Inventory
- Sweeping
- Inspections
- Clean break room
- Clean windows
- Organize areas
- Quality inspections
- Paint walls/breakroom
- Touch up painting in building
- Clean parking lot/pick up litter

Construction industry

- Cleaning and inspecting tools
- Calculating estimates
- Calling in orders

Transportation industry

- Riding along on buses as an aide or observer
- Working in dispatch

Health care

- Charting
- Checking medication expiration dates
- Cleaning wheelchairs, commodes and other equipment
- Feeding residents

You can find more light-duty work ideas broken down by industry at sfmic.com/transitionalwork.

Your return to work

We strive to return employees who are injured on the job to work as soon as they're medically able. We can provide temporary modified work that fits within your medical restrictions. Ultimately, our goal is to help you heal and get you back to your regular job.

You can help in the recuperation process by:

- Staying in regular contact with our return-to-work coordinator (or your supervisor)
- Informing us of all scheduled doctor visits for your work injury
- Providing us with copy of the physician's Work ability/Return-to-work form immediately after each doctor's visit
- Communicating with SFM, our workers' compensation insurer, including the claims representative and nurse case manager
- Following your doctor's restrictions and communicating to the doctor that we provide light-duty work

We care about your safety and well-being. Taking these steps will help ensure that you're receiving the appropriate workers' compensation benefits on time and that you're healing properly.

Su regreso al trabajo

Nos esforzamos por que los empleados lesionados en el trabajo vuelvan a trabajar tan pronto como puedan desde el punto de vista médico. Podemos proporcionar modificaciones temporales en el trabajo para que el trabajo coincida con sus restricciones médicas. En última instancia, nuestro objetivo es ayudarle a recuperarse y volver a su trabajo habitual.

Puede colaborar con el proceso de recuperación haciendo lo siguiente:

- manteniéndose en contacto regular con nuestro coordinador de reincorporación al trabajo (o con su supervisor);
- informándonos sobre todas las visitas programadas al médico por su lesión laboral;
- proporcionándonos una copia del formulario de capacidad de trabajo/reincorporación al trabajo del médico, inmediatamente después de cada visita al médico;
- comunicándose con SFM, nuestra aseguradora de compensación para trabajadores, incluido el representante de reclamaciones y el jefe de caso de enfermería;
- siguiendo las restricciones de su médico y comunicándole a su médico que le proporcionamos trabajo ligero.

Nos preocupamos por su seguridad y bienestar. Tomar estos pasos ayudará a garantizar que recibe a tiempo los beneficios adecuados de compensación para trabajadores y que se está recuperando correctamente.