

## **Workers Compensation Medical/Loss Time**

If you are injured while at work and are planning to seek immediate medical attention or end up seeking medical attention please make sure to read all the information below.

- Please make sure that you have noted on the Accident Report Form that you are going to a Dr. to be seen for your work related injury.
  - o Also contact the Human Resources office at 781-283-2231 to notify us prior to being seen as some Dr.'s offices require pre-approval from our workers compensation company for your visit.
- If you are going to be out due to a work related injury:
  - o you need to make sure to have a note from your treating physician putting you out of work
  - o please have this note faxed to the Human Resources office at 781-283-3663
- If you are managing your own care for your work related injury:
  - o please make sure that both FutureComp and the Human Resources Office receive updates from your treating physician
  - o The treating physician may fax us at:
    - FutureComp – 610-537-9928
    - Human Resources – 781-283-3663
- Once your physician has cleared you to return to work:
  - o Fax the return to work information to both FutureComp and the Human Resources Office.
  - o If there are restrictions with your return to work the Human Resources Office will go over these restrictions with your department to make sure they are able to accommodate the restriction and the Human Resources Office will contact you directly to confirm your return to work date.
- If you would like to make changes or stop any of your Wellesley College benefits while you are out of work, please contact our Benefits Specialist at 781-283-2212.
- Please make sure to provide your Dr.'s offices with our workers compensation company information below. You will receive a confirmation letter from FutureComp when your claim has been approved which will include a claim number to provide to your Dr.'s office for billing purposes.
  - o Any bills that you receive directly should either be forwarded by you to FutureComp or you should contact your physician's office to have them redirect the bills to FutureComp

FutureComp/York Risk Services  
Attn: OSC  
PO Box 183188  
Columbus, OH 43218  
Main # - 781-376-2706

**Please sign and return this page to the Human Resources Office immediately**

- While you are out due to your work related injury you must make arrangements with the Human Resource Office to pay for the employee portion of your health and/or dental benefits, and/or supplemental Life insurance, if applicable.

**Benefits Payment Options:**

Please check off which option you would prefer and return this form to the Human Resources office by fax, mail or drop off.

\_\_\_\_\_ Please supplement my time with sick/vacation/personal time so that I am receiving full pay while I am out due to my work related injury.

\_\_\_\_\_ Please supplement my time with sick/vacation/personal time to cover my health/dental benefits/supplemental Life insurance.

\_\_\_\_\_ I do not wish to supplement my time and please bill me for my portion of my health/dental benefits/supplemental Life insurance.

\*\*If you run out of time to continue to supplement we will then start to bill you for your portion of you health and/or dental benefits. If you have questions/concerns about paying for your benefits please contact our Benefits Specialist at 781-283-2212.

**Important - Please Read:** If the Human Resources Office does not receive this form or hear from you directly then you will go into an unpaid status and will be automatically billed for you benefits. Continuation in the benefits programs while on leave, requires you continue to make your plan contributions. Failure to pay your contributions will result in removal from the benefit plan. Removal will be effective following 60 days of non-payment.

Please feel free to call us at 781-283-2231 with any other questions or concerns.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

# Please sign and return this page to the Human Resources Office immediately

[Type the abstract of the document here. The abstract is typically a short summary of the contents of the document.]

## SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Member: \_\_\_\_\_

Address or Location No.: \_\_\_\_\_

**WHEN:** Date and Time of Accident: \_\_\_\_\_ Reported to: \_\_\_\_\_  
Report to Supervisor or First Aid Delayed? Yes  No  If "Yes," Why: \_\_\_\_\_

**WHO:** Injured Person: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Dept.: \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Age: \_\_\_\_\_  
Full time  Part time  Temporary  Student  Date of Hire: \_\_\_\_\_

**INJURY/LOSS:** Nature/Extent of Injuries or Property Damage: \_\_\_\_\_

**WHERE:** Exact Location Where Accident Occurred: \_\_\_\_\_

**WHAT:** Type of Accident: \_\_\_\_\_  
Was employee doing something other than required duties at time of accident?  
Yes  No  If "Yes," what and why: \_\_\_\_\_

Description of Accident (detail what employee was doing, and what physical objects, tools, machines, structures of equipment were involved): \_\_\_\_\_

**WHY:** Determine Accident causes and comment fully here.

1) Immediate Causes: 1) Unsafe act(s) / unsafe condition(s) : \_\_\_\_\_

2) Basic Causes: 2) Management, people, equipment, material, environment : \_\_\_\_\_

**PREVENTION:** What should be done and by whom to prevent recurrence of this type of accident? \_\_\_\_\_

What action are you taking to see that this is done? \_\_\_\_\_

Follow-up requirements: \_\_\_\_\_

Date of follow-up: \_\_\_\_\_

Investigated By \_\_\_\_\_ Date: \_\_\_\_\_  
Supervisor's Signature: \_\_\_\_\_ Date of this report: \_\_\_\_\_  
Department Manager's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Executive's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Accident Reporting Form

Today's Date:

Employee Information	Employee Name		Incident Date												
	Job Title		Department												
	Shift	Date of Hire													
	Current Mailing Address														
	Home Phone	Cell Phone	Date of Birth												
	Employee Signature (if available):		Date:												
	Incident Description														
Incident Detail	Supervisor		Reported To												
	Witnesses														
	Location where injured														
	Medical Treatment Required: Yes <input type="checkbox"/> No <input type="checkbox"/>														
	Treating Physician/Facility														
	Address														
	Phone Number														
	Injury Description														
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Body Part</th> <th style="width: 33%;">Side of Body</th> <th style="width: 34%;">Type of Injury (i.e. sprain/strain, bruise)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Body Part	Side of Body	Type of Injury (i.e. sprain/strain, bruise)									
	Body Part	Side of Body	Type of Injury (i.e. sprain/strain, bruise)												
Will you lose any time due to this injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		First day out of work:													
Please put in any additional information here:															
Notes/Comments															

When completed please fax form to the Human Resources office at 781-283-3663 and to the Health and Safety Department at 781-283-3643.