MN Department of Labor and Industry
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5032 or 1-800-342-5354
Fax: (651) 284-5731

First Report of Injury

See Instructions on Reverse Side

PRINT IN INK or TYPE
ENTER DATES IN MM/DD/YYYY FORMAT

FRO1

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY #	2. OSHA case #	3. Time employee began work on date of injury ☐ am ☐ pm	
4. DATE OF CLAIMED INJURY	5. Time of injury ☐ am ☐ pm	6. Date of death	# of dependents (if death is related to injury)
7. EMPLOYEE Name (last, suffix, first, middle)		8. Gender ☐ M ☐ F	9. Marital status ☐ Married ☐ Unmarried
10. Home address		11. Home phone #	12. Date of birth / 13. Date hired
City State Zip Code		14. Occupation	15. Regular department / 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage	18. Rate per hour	19. Hours per day	20. Days per week	Normal work schedule Sun - Sat (S M T W T F S) ☐ ☐ ☐ ☐ ☐ ☐ ☐	21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*	24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No Name and address of the place of the occurrence	26. Date of first day of any lost time	27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI
	28. Date employer notified of injury	29. Date employer notified of lost time
	30. Return to work date	31. RTW same employer ☐ Yes ☐ No / 32. RTW with restrictions ☐ Yes ☐ No
33. Treating physician (name)	34. Extent of medical treatment (check all that apply) ☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital ☐ Emergency room ☐ Hospitalization more than 24 hours ☐ Future major medical anticipated	
35. Certified Managed Care Organization (if any)		

36. EMPLOYER Legal name ISD #314 BRAHAM	37. EMPLOYER DBA name (if different)	
38. Mailing address 531 ELMHURST AVE S	39. Employer FEIN 41-600158	40. Unemployment ID # 07970973
City State Zip Code BRAHAM MN 55006	41. Employer's contact name and phone # CONNIE GELLE - 320-396-5199	
42. Physical address (if different)	43. Witness (name and phone) - if more than 1 attach a separate sheet	
City State Zip Code	44. NAICS code	45. Date form completed

46. INSURER name EMC INSURANCE COMPANIES	51. CLAIMS ADMIN COMPANY (CA) name (check one) ☐ Insurer ☐ TPA	
47. Insured legal name and FEIN	52. CA address	
48. Policy # (including effective dates) or self-insured certificate # 4X3-060-30-11	City State Zip Code	
49. Insurer FEIN 0	50. Date insurer received notice	53. CA FEIN / 54. CA claim #

55. To be completed by the CA:	Claim type code:	Type of loss code:	Late reason code:	Salary paid in lieu of comp?	Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see www.usa.gov/Business/Business-Gateway.shtml and click on "Get an Employer ID Number".
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

SUPERVISOR'S REPORT OF ACCIDENT

This form should be completed by the supervisor as soon after a work accident as possible. It is useful in gathering information for investigating accidents and their causes so that corrective action can be taken and future accidents avoided. Every accident should be investigated and the causes corrected.

Name of Employee: _____ City/City Organization: _____ Dept.: _____

Date of Accident: _____ Time of Accident: _____ Did employee lose time from work? YES ☐ NO ☐

Hours lost on day of accident: _____ Has employee returned to work? YES ☐ NO ☐

Employee's job title: _____ Years of employee's service with City/City organization: _____

Years employee has been in present job: _____ Number of hours employee works per week: _____

GIVE US YOUR HONEST COMMENTS ON QUESTIONS BELOW. WE ARE NOT TRYING TO BLAME ANYONE. YOUR OPINION MAY HELP US PREVENT ACCIDENT REPETITION.

PLEASE ANSWER THE FOLLOWING:

CHECK "YES" OR "NO"

1.	HAD INJURED PERSON BEEN PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS?	YES ☐	NO ☐
2.	DID INJURED PERSON VIOLATE ANY INSTRUCTIONS?	YES ☐	NO ☐
3.	WAS NECESSARY PROTECTIVE EQUIPMENT WORN? (IF APPLICABLE)	YES ☐	NO ☐
4.	DID POOR HOUSEKEEPING CONTRIBUTE TO INJURY?	YES ☐	NO ☐
5.	DID HORSEPLAY CAUSE THE INJURY?	YES ☐	NO ☐
6.	WAS INJURY CAUSED BY SOMETHING THAT NEEDED REPAIRS?	YES ☐	NO ☐
7.	SHOULD A GUARD BE PROVIDED?	YES ☐	NO ☐
8.	DID ANY BODILY DEFECT CONTRIBUTE TO INJURY?	YES ☐	NO ☐
9.	WAS INJURY CAUSED BY AN UNSAFE ACT?	YES ☐	NO ☐
10.	DID INJURED REPORT THE INJURY TO YOU, THE SUPERVISOR, IMMEDIATELY?	YES ☐	NO ☐

ACCIDENT. (Describe what the injured employee was doing at the time of the accident, what happened, who was involved, nature of the injury.) _____

_____

_____

Witnesses' Names _____

UNSAFE ACTS. (Did the injured employee or another person do something incorrectly?) _____

_____

_____

_____

UNSAFE CONDITIONS. (What unguarded or unsafe condition of machinery, equipment, building or premises was involved?) _____

_____

_____

ACTIONS TAKEN. (After the injury, what did the employer do to correct the conditions that caused the injury?) _____

_____

_____

REMEDIES. (What should the employer do to prevent other injuries like this?) _____

_____

_____

MEDICAL CARE. Did the employee go to the Doctor or Hospital? YES ☐ NO ☐ If yes, please complete the following:

Name of Doctor or Hospital: _____ Date of initial visit: _____

Address: _____ Telephone number: _____

AS SUPERVISOR, DO YOU FEEL THAT THIS INJURY SHOULD BE COVERED UNDER WORKERS' COMPENSATION? **YES ☐ NO ☐**

Reasons why or why not: _____

_____

Report Submitted By: _____ Date: _____

COMPLETION INSTRUCTIONS FOR SUPERVISORS' REPORT OF ACCIDENT (SRA)

The primary purpose of the SRA is to investigate the accident. It is also used to report the accident to the central office where the First Report of Injury is then completed by administrative personnel. The SRA should be filled out as soon as possible after the accident.

If the SRA is incomplete or delayed, corrective action may also be delayed. A delay in taking corrective action will probably result in the occurrence of a similar accident.

The initial information asked for at the top of the SRA concerning the injured person's name, occupation, age, job history and loss of time from work is self-explanatory, but very necessary for eventual completion of the First Report of Injury.

The following is a line-by-line set of instructions for completing of the SRA by the **Supervisor** of the injured employee. Concrete examples of important parts of the form are given for your use. This report should not be completed by the injured employee.

QUESTIONS

1. Was proper instruction given to the employee on how to do the job safely? Supervisors should instruct their employees on how to do the job efficiently and safely.

2. Referred to in question #1.

3. The supervisor should have told the employee what personal protective equipment is necessary to do the job. Did the employee wear the personal protective equipment when this job was being done?

4. Was the work area clean and well organized? i.e., scraps on the floor, blocked aisles, wet floor, spilled food, etc.

5. Was there inadequate supervision? Did horseplay or practical jokes contribute to the accident?

6. Was the injured person using equipment that was unsafe and in need of repair? i.e., broken ladder, bad electric cord on drill, etc.

7. Would a guard prevent another accident from happening? i.e., guard around the belts and pulleys, railing properly in place, guard on saw, etc.

8. Did this person have any bodily defects which might have helped cause the accident? i.e., poor vision, previous back injury, etc.

9. Most injuries are caused in part by unsafe acts. An Unsafe Act is something that the injured person or another person did, that he or she should not have done, which led to the accident. Below is a list of the most common unsafe acts and contributing factors:

    1. Operating without authority
    2. Failure to warn or secure
    3. Operating at unsafe speed
    4. Making safety devices inoperative
    5. Using equipment, tools, materials or vehicles unsafely
    6. Using defective equipment, materials, tools or vehicles
    7. Failure to use personal protective equipment
    8. Failure to use equipment provided (except personal protective equipment)
    9. Unsafe loading, placing and mixing
    10. Unsafe lifting and carrying (including insecure grip)
    11. Taking an unsafe position
    12. Adjusting, clearing jams, cleaning machinery in motion
    13. Distracting, teasing
    14. Poor housekeeping practices
    15. Disregard of instructions
    16. Lack of knowledge or skill
    17. Act of other than injured
    18. Others .....

10. The accident should have been reported immediately to the supervisor; was it?

Accident

1. Describe what the injured was doing at the time of the accident.
2. What happened?
3. Who was involved?
4. What injuries resulted?

Example: John was drilling a hole in the ceiling and chips of plaster fell into his eye. (This answers questions 1 and 2.) John got chips of plaster in his eye, resulting in a scratch to his eye. John was wearing his prescription glasses. (This answers questions 3 and 4.)
Note the names of witnesses, if any.

Unsafe Act

Refer to question 9 above and examples of Unsafe Acts. Example: John was not wearing proper personal protective equipment.

Unsafe Conditions

1. Defective tools, equipment, substances
2. Unsafe design or construction
3. Hazardous arrangement
4. Improper illumination
5. Improper ventilation
6. Improper dress
7. Poor housekeeping
8. Congested area
9. Other

Action Taken Example: John has been re-instructed to wear proper personal protective equipment such as goggles or face shield when drilling overhead.

Remedy Example: Standard safety policy should be adopted that requires use of personal protective equipment. This policy should be strictly enforced by the supervisors.

Medical Care: Include all medical information that is known at this time. Do not delay the completion of this form for more complete information.

As supervisor, do you feel that this injury should be covered under workers' compensation benefits? As a general rule, if the employee is injured while at work, that injury is covered under workers' compensation. However, if you as supervisor, have reason to suspect that the injury did not occur at work, please tell us. This is only an opinion and by itself will not deny benefits.

BRAHAM AREA SCHOOLS, ISD #314
Isanti, Kanabec, Chisago & Pine Counties
531 Elmhurst Avenue South
Braham, MN 55006

District Office 320-396-3313
HS Office 320-396-4444
Elem Office 320-396-3316
www.braham.k12.mn.us

Ken Gagner, Superintendent
Shawn Kuhnke, HS Princ/ Act Dir
Jeffrey Eklund, Elem. Principal
Tammi Johnson, Dean of Students

Dear Healthcare Provider,

Braham Area Schools strive to provide a safe workplace for all employees. However, we understand that accidents will still occur. With this in mind, we have developed a return to work program (RTW) that encourages employees to rejoin the workforce as soon as possible.

Studies show that injured employees often recover faster when they remain active within their restrictions. We also know that employees who lose interaction with fellow employees can begin to feel like an "outsider" and become alienated from their work friends.

For these and other reasons, Braham Schools support work as therapy and we encourage you to help our injured employee return to work under reasonable restrictions as soon as possible. We have a full list of alternate duties that fit nearly any restrictive limitations. A partial list is attached. If you would like more details or if you would like to discuss in detail what assignments are available for a specific employee please call Connie Gelle at 320-396-5199.

Thank you for your time.

Ken Gagner

Ken Gagner
Superintendent of Schools

Report of Workability

PLEASE FAX IMMEDIATELY TO:
EMC Insurance Companies: 1-888-992-6132

Date of Service: _____ Date of Injury: _____
Patient Name: _____ Claim #: _____
Employer: _____ Date of Birth: _____

Diagnosis/ICD9 Code: Is condition work related? ☐ Yes ☐ No

Treatment Plan:

Medications:

Date of most recent examination by this office: ___/___/_____. The next scheduled visit is: ☐ as needed OR ___/___/_____

1. ☐ Recommended his/her return to work with no limitations on _____.
2. ☐ He/She may return to work on _____ with the following limitations

DEGREE	LIMITATIONS
O **Sedentary Work**. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met. O **Light Work**. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls. O **Medium Work**. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds. O **Heavy Work**. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds. O **Very Heavy Work**. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.	1. In an 8 hour work day, patient may: a. Stand/Walk ☐ None ☐ 1-4 Hours ☐ 4-6 Hours ☐ 6-8 Hours b. Sit ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours c. Drive ☐ 1-3 Hours ☐ 3-5 Hours ☐ 5-8 Hours 2. Patient may use hands for repetitive: ☐ Single Grasping ☐ Pushing & Pulling ☐ Fine Manipulation 3. Patient may use feet for repetitive movement as in operating food controls: ☐ Yes ☐ No 4. Patient is able to: Frequently / Occasionally / Not at all a. Bend ☐ ☐ ☐ b. Squat ☐ ☐ ☐ c. Climb ☐ ☐ ☐

PRE-EXISTING OR OTHER CONDITIONS THAT AFFECT THIS INJURY: _____

3. ☐ These restrictions are in effect until _____ or until patient is reevaluated.
4. ☐ He/She is totally incapacitated at this time. Patient will be reevaluated on _____.

NAME (Type or Print)	SIGNATURE		DEGREE
ADDRESS	STATE	LICENSE #/REGISTRATION #:	
CITY STATE ZIP CODE	PHONE # (include area code)	DATE SIGNED	

INSTRUCTIONS FOR COMPLETING REPORT OF WORK ABILITY

Each health care provider directing the course of treatment for an employee who alleges to have incurred an injury on the job must complete a Report of Work Ability within 10 days of a request for a Report of Work Ability from the insurer, or at the applicable interval (Minn. Rules 5221.0410, subp. 6):

1. every visit if visits are less frequent that one every two weeks;

2. every 2 weeks if visits are more frequent than once every two weeks, unless work restrictions change sooner; and

3. upon expiration of the ending or review date of the restrictions specified in a previous Report of Work Ability.

The Report of Work Ability must either be on this form or in a report that contains the same information. The Report of Work Ability must:

- Identify the employee by name, WID or social security number, and date of injury.
- Identify the employer at the time of the employee's claimed work injury.
- If known, identify the workers' compensation insurer at the time of the claimed injury, or the workers' compensation third-party administrator. Also indicate this workers' compensation payer's claim number.
- Indicate the date of the most recent examination by this office. The Report of Work Ability should be completed based on this evaluation.
- Identify the appropriate option which best describes the employee's current ability to work by checking box 1, 2, or 3.

  1. If the employee is able to work without restrictions, fill in the beginning date.

  2. If the employee is able to work with restrictions, fill in the date any restriction of work activity is to begin and the anticipated ending or review date. Describe any restrictions in functional terms (e.g., employee can lift up to 20 pounds, 15 times per hour; should have 10 minute break every hour).

  3. If the employee is unable to work at all, fill in the date the restriction of work activity is to begin and the anticipated ending or review date.

- Indicate the date of the next scheduled visit or indicate that additional visits will be scheduled as needed.
- Identify the health care provider completing the report by name, professional degree, license or registration number, address and phone number.
- Include the signature of the health care provider and date of the report.

The health care provider must provide the Report of Work Ability to the employee and place a copy in the medical record.

If you have questions, please call the claim representative or the Department of Labor and Industry, Workers' Compensation Division at (651) 284-5030 or 1-800-342-5354.

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

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