Town of Duxbury, Massachusetts

MEMORANDUM

DATE: September 12, 2019

TO: All Department Heads and Supervisors

FROM: Jeannie Horne, Human Resources Director

RE: Workers Compensation: UPDATED OSHA REQUIREMENT TO REPORT WORK RELATED INJURY/ILLNESS WITHIN 8 HOURS, Wages, Time Away From and Return to Work

Please use the following information to report ALL WORK RELATED INJURY/ILLNESS WITHIN 8 HOURS, calculate related wages, handle time away from and return to work (this memo and below forms are posted on the HR webpage at https://www.town.duxbury.ma.us/sites/duxburyma/files/uploads/town_of_duxbury_workers_compensation_reporting_and_pay_process_2019.pdf

1. If an employee is injured or becomes ill on the job, the supervisor must *immediately* complete the following attached forms:
   a. **Supervisor's Report of Accident – Intake Form** (completed by supervisor)
   b. **Worker's Compensation Telephone Reporting Worksheet** (completed by supervisor)
   c. **Accident Investigation Form** (completed by supervisor)
   d. **Medical Authorization** (completed by employee)
   e. **Witness Statement** (completed by witnesses)
   f. **MyMatrixx Form** for treatment and related prescriptions (completed by supervisor and given to the employee)

2. The supervisor then emails completed forms (a, b, c, d and e) to ***MIIA.Workers.Comp@aon.com*** (or fax to 617/753-9987 and call MIIA at 800/799-6442 to initiate the claim).

3. Copies of **Supervisor's Report of Accident, Worker's Compensation Telephone Reporting, Accident Investigation, Medical Authorization, Witness Statement and MyMatrixx** forms must be provided to Human Resources once the claim has been reported to MIIA.

4. During the first five calendar days of absence, the employee must use his/her available sick, vacation, personal or compensatory time, or receive no pay and the supervisor must report this time accordingly on the payroll worksheets. (The date of the injury is day one, the first five days include weekends or days not normally scheduled to work.)

5. If the employee returns to work before day 6, resume normal wage payments.

6. If the employee does not return to work before day 6:
   a. Contact Human Resources to determine if the employee is eligible for FMLA leave.
   b. Pay will be provided at 60% (4.8 hours of an 8 hour day) by our Workers Compensation Insurance carrier. No taxes are withheld, checks are mailed to the Human Resources Office for pick up by the employee.
   c. Pay may be provided for remaining 40% (3.2 hours of an 8 hour day supplementing Workers Compensation pay) via the employee's available sick, vacation, personal or compensatory time. The order of usage for the paid time is determined by the employee.

7. Employees must continue to pay for their benefit deductions while on Workers Compensation. These deductions can continue via payroll as long as the employee is receiving pay from the Town via sick, vacation, personal or compensatory time. Otherwise, the Human Resources Office must be notified to request direct payment for these benefits.

8. When the employee is cleared to return to work, notify Human Resources to discuss/review the return to work plan.

WHEN IT DOUBT, ALWAYS REPORT WORKPLACE INJURY OR ILLNESS WITHIN 8 HOURS.

878 Tremont St., Duxbury, MA 02332
Fax 781-934-9011
781-934-1100 ext. 5410
Email horne@town.duxbury.ma.us

MIIA

Duxbury, Town of

SUPERVISOR'S REPORT OF ACCIDENT- INTAKE FORM

DATE OF INJURY:_____TIME OF INJURY_____ ACKNOWLEDGE/DATE REPORTED_____

DESCRIPTION OF ACCIDENT; WHAT WAS EMPLOYEE DOING? WHAT HAPPENED?WHY?_____

_____

*CAUSE:_____*NATURE:_____ *BODY PART:_____*OCCUPATION_____

EMPLOYEE NAME_____ SOCIAL SECURITY #_____
SEX(M or F)_____ MARITAL STATUS_____ DATE OF BIRTH_____
DATE OF HIRE_____ DEPARTMENT_____
SUPERVISOR NAME _____ PHONE NUMBER_____

EMPLOYEE ADDRESS_____
TELEPHONE NUMBER: HOME_____WORK_____
CELL_____ EMAIL_____

LOCATION ACCIDENT OCCURRED_____(Include Building or School Name)
INJURED ON PREMISE YES☐ NO ☐
AVERAGE WEEKLY WAGE_____
DID EMPLOYEE LOSE TIME FROM WORK? YES☐ NO☐
NUMBER OF DEPENDENTS_____
DID EMPLOYEE RETURN TO WORK YES☐ NO☐
IF YES, DATE RETURN TO WORK:_____ Full Duty YES☐ NO☐ Modified Duty YES☐ NO☐
TIME BEGAN WORK_____
IF NO, LAST DAY WORK_____1ST DAY OF DISABILITY_____5TH DAY OF DISABILITY_____ (calendar days)
WAS MEDICAL TREATMENT SOUGHT? YES☐ NO☐
MEDICAL FACILITY _____

DATE REPORTED AS WORK RELATED: _____
WITNESS _____
TO WHOM WAS INJURY REPORTED TO _____

*******Supervisor's Complete Below*********

CAUSE-UNSAFE ACT OR CONDITION; OBJECT/SUBSTANCE CAUSING INJURY

_____

_____

WAS EMPLOYEE WEARING SAFETY GEAR? YES☐ NO ☐ IF NO, EXPLAIN)_____

ACTION TAKEN TO PREVENT SIMILAR ACCIDENTS_____

_____

REMARKS_____

_____

Investigated By_____ Date_____

Reviewed By_____ Date_____

☐ School Nurse ☐ Supervisor

***See page 2 for selection listing**

Red Font: New OSHA Require data

2/1/19

Cause	Body Part	Nature	Occupation/Job Code
STRUCK AGAINST	ABDOMEN	INSECT BITE	ADMIN ASSISTANT
STRUCK BY	ANKLE	AMPUTATION	ADMINISTRATION
FALL DIFF LEVEL	ARM	ASPHYXIATION	ANIMAL CONTROL
FALL SAME LEV.	BACK	ANIMAL BITE	CARPENTER
CAUGHT BETWEEN	BOD PTS, NEC	BURN/SCALD	CLERICAL
HOLDING PNT UP	BODY SYSTEM	CARPAL TUNNEL	CONSERV. AGENT
LIFTING	BRAIN	BURN(CHEMICAL)	COOK
LIFT OBJ LOWER	BUTTOCKS	CONCUSSION	DRIVERS NOC
CARRYING	CHEST/RIBS	INFECT. DISEASE	ELECTRICIAN
BENDING/REACH	DIGEST SYS	CONTUSION	EMT
WHEELCHAIR	EAR	CUT/PUNCTURE	EQUIP/OPERATORS
FALL ON STAIRS	ELBOW	SPLINTER	FOREMAN
FALL OUTSIDE PR	EXCRET SYS	DERMATITIS	GENERAL ADMIN
STRUCK BY DOOR	EYES	POISON IVY	GROUNDSKEEPER
HANDTOOLS	FINGER	DISLOCATION	HARBORMASTER
POWER HAND TOOL	FOOT	ELECTRIC SHOCK	HEALTH PROF
RUB/ABRADE	GROIN	FRACTURE	INSPECTOR
SPLASHING LIQ.	HAND	FROSTBITE	LABORERS
FOREIGN BDY EYE	HEAD	HEARING LOSS	LIBRARIAN
STEP ON OBJ.	HEART	VISION LOSS	LIFEGUARD
CUTS/NOT NEEDLE	HEEL	HEAT EXHAUSTION	LINEHAUL (ROAD)
PUNCH NDLE DISC	HIP	HERNIA	LINEMAN
PUNCH NDLE USE	JAW	HUMAN BITES	LPN
COLL /PERSON	KNEE	HUMAN SCRATCHES	MAINTENANCE WKR
STRUCK BY PNT	LEG	INFLAM MUSCLES	MARINE WORKER
OCCUP DISEASE	LO EXTR	POISONING	MASON/PLASTERER
EXPL & FIRE	LO EXTR MULT	PNEUMOCONIOS	MECHANIC
COMM.DISEASE	LO EXTR,NEC	SUNBURN	METER READER
BODY REACTION	LOWER LEG	SPRAIN	MISC NOC
ANIMAL BITE	MOUTH	STRAINS	PAINTER
OVEREXER/STRESS	MULTIPLE PTS	ULCERATIONS	PLANT OPERATOR
ELECTRIC SHOCK	MUS/SKEL SYS	VARICOSITIES	PLUMBER
TEMP. EXTREME	NECK	HEMORRHOIDS	REFUSE COLLECT
CONTACT TOXIC	NERV SYS/STRESS	MULT.INJURIES	REFUSE DRIVER
ASSAULT	NOSE	FOREIGN BODY	SCH/BUS/DRIVER
INSECT BITE	OTH BOD SYS	MENTAL DISORDER	SCH/CAFETERIA
MOTOR VEH ACC.	PELVIS	NERV SYS/STRESS	SCH/CUSTODIAN
TRIPPED/TURNED	RESP SYS	RESP. SYSTEM	SCH/NURSE
CLIMBING	SCALP	EYE IRRITATION	SCHOOL TEACHER
PULLING HOSE	SHOULDER	PROTH DEVICE	SCHOOL/AIDE
CONTAGIOU PLANT	SKIN	OCC. DISEASE	SCHOOL/CLERICAL
SHOT	TEETH	HEART ATTACK	SCHOOL/CROSSING
HLD-UP RIOT	THIGH	HYPERTEN/STROKE	SECRETARY
ROBBERY	TOES	FAINTING	SUPERINTENDENT
HORSEPLAY/FIGHT	TRUNK	SCARRING	TEMP/OTHER
WINDBLOWN OBJ.	TRUNK MULTI	cardio/vascular	TEMP/SUMMER
REPETITIVE MOT.	UP EXTR	NOT CLASSIFIED	TREE WORKER

MIIA WORKERS COMPENSATION TELEPHONE REPORTING WORKSHEET

Town of Duxbury, 878 Tremont St. Duxbury, MA. 02332

Complete this worksheet completely prior to calling MIIA at:

*** 1-800-799-6442 ***

This Call-in Service is available 24 hours a day, 7 days a week. The Supervisor or Administrative Assistant (not the employee) should phone in this information to MIIA as soon as the injury is reported.

Employee's Last name	
First Name	
Middle Initial	
Home Phone	
Social Security #	
Home Address	
City, State, Zip	
Marital Status	
# of Dependents	
Date of Hire	
Date of Birth	
Estimated Average Weekly Wage	
Federal Tax ID #	04-6001136
Industry Code	99
Workers compensation Policy No.	07-046
Department #	N/A
Employer's Location Code (Department)	
Date of Accident	
Time of Accident	
Location of Accident	
First Day of Disability	
Fifth Day of Disability (if applicable)	
Date Reported as Work Related	
Description of Accident	
To Whom was Injury Reported?	
Name/Phone of Witnesses	
Date Reported to MIIA	
Name of Person Reporting to MIIA	

By calling MIIA and providing the information on this form, you eliminate the need to fill out a Form 101 Report of Injury and a MIIA 1-2-3 Initial Intake form.

However, completion of the Supervisor's Report of Accident – Intake Form, Medical Authorization, and Witness Statement forms is still required.

Please send copies of these forms and the MIIA Worker's Compensation Telephone Reporting Worksheet to Jeannie Horne in the Human Resources Office on the same day the accident was reported.

Ed. 2/09 **Revised

MIIA Massachusetts Based Member Driven

ACCIDENT INVESTIGATION REPORT
PART 1

Members Name: Town of Duxbury

Instructions: Supervisors should use this form to report all work-related injuries, illnesses, or "near miss" incidents - no matter the severity. This aids in the identification and correction of hazards and in the prevention of future similar type injuries from occurring. The Supervisor is responsible for contributing to all pages of this report. The Supervisor and Injured Employee must complete the EMPLOYEE's STATEMENT part of this report. All photos can be inserted as images in the Part 2 photo page. All pages must be completed.

This is a report of a work-related: ☐ Injury ☐ Illness ☐ Near Miss ☐ Fatality

Employee Name: Department:

Supervisor's Name: Department:

Date of Occurrence: Incident Time: ☐am ☐pm

Loss of Work Time Began (If none, indicate N/A):

INJURY TYPE (Most serious, check all that apply)

☐ Burn -Heat/Chemical	☐ Strain/Sprain/Break	☐ Animal Bite/Sting	☐ Fatality
☐ Cut, Laceration, Puncture	☐ Inhalation/Reaction	☐ Skin Irritation	☐ Head Trauma
☐ Bruise	☐ Abrasion Scrape	☐ Human Bite	☐ Ambulance Transport
☐ Needlestick	☐ Eye Irritation/Cut/Scratch	☐ Illness	☐ Other
☐ Crushing Injury			Explain:

Parts of the body affected:

DESCRIPTION OF THE INCIDENT (Where, What, Why, When, etc.)

Where, exactly, did the incident occur?

What was the injured employee doing at the time of the incident?

Describe, step-by-step, what led up to the incident (i.e., EE was pruning trees, while on ladder, slipped...).

Please complete all pages

WITNESS INFORMATION (List the names, titles & dept. of anyone witness to the incident.)

Name: Title:

Dept./Other/Phone#:

Name: Title:

Dept./Other/Phone#:

Name: Title:

Dept./Other/Phone#:

Investigation report completed by: Date:

Employee's Supervisor: Date:

Department Head: Date:

CAUSES OF THE ACCIDENT

Using the list below, please identify cause(s) or potential cause(s) that contributed to this incident.
Check all that apply.

- ☐ Improper instruction
- ☐ Lack of training or skill
- ☐ Operating without authority tool/eqpt
- ☐ Improper storage of chemicals
- ☐ Poor housekeeping
- ☐ Failure to use proper personal protective equipment
- ☐ Failure to use available tool/equipment
- ☐ Struck by person
- ☐ Struck by object
- ☐ Failure to lockout
- ☐ Inadequate lighting
- ☐ Inadequate ventilation
- ☐ Unsafe lifting
- ☐ Inoperative safety device
- ☐ Unsafe arrangement or process
- ☐ Physical or mental impairment
- ☐ Slip/Fall same level
- ☐ Slip/Fall from height
- ☐ Unsafe clothing
- ☐ Improper maintenance
- ☐ Unsafe/Defective
- ☐ Distraction
- ☐ Improper use of equipment
- ☐ Trip
- ☐ Slip/Wet or Icy surface
- ☐ Caught/Between
- ☐ Vehicle incident

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

If 'Yes' provide explanation:

Please complete all pages

ACCIDENT PREVENTION

What changes are recommended to prevent future occurrences of similar incidents?

- ☐ Stop this activity/task
- ☐ Redesign the activity/task
- ☐ Redesign the workstation
- ☐ Train the employee(s)
- ☐ Train the supervisor(s)
- ☐ Other
  Explain:
- ☐ Enforce existing policy/procedure
- ☐ Develop a new policy/procedure
- ☐ Additional personal protective equipment
- ☐ Additional oversight by supervisor(s)
- ☐ Routinely inspect for the hazard
- ☐ No Change recommended at this time

LIST BELOW RECOMMENDATIONS FOR PREVENTION AND IMPROVEMENT

Recommendations:

What should be (or has been) done to facilitate the recommendations identified above?

EMPLOYEE'S STATEMENT

Employee needs to complete this form with along with the Supervisor to aid in the identification of hazards, deduce a corrective action and sign-off on corrective action completion.

Date of Incident: Where, exactly, did the incident occur?

Describe step-by-step, what led up to the incident; and include if proper protective equipment was being worn or provided.

What/How do you feel this could have prevented this incident/injury?

Was proper training provided?

Please provide corrective action or suggestion for preventing future similar type incidents.

Employee's Signature: _____ Date:

Name:

Supervisor's Signature: _____ Date:

Name:

Please complete all pages

Member Services
One Federal Street, Boston Massachusetts 02110
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

MEDICAL AUTHORIZATION

To: _____ Date: _____

_____

_____

and any other physician, hospital, clinic or medical care provider, presently unknown to me, who may have or subsequently acquire information concerning my physical condition. You are hereby authorized to give MIIA Member Services and/or any of its representatives, all information, facts and particulars, including reports, records, results from diagnostic tests, X-rays and statements of charges which may be requested regarding my medical condition, diagnosis, treatment and to furnish them copies of such reports. You are further authorized to allow any physicians appointed by them to review all such reports, records and X-rays in your possession.

I am willing that a photo static copy of this authorization be accepted with the same authority as the original.

This information is to be used for handling my claim from an occupational injury or illness occurring on or about _____ and for no other purpose, now or in the future.

This authorization is valid for the duration of the above condition.

_____ _____

(Employee's signature) (Date)

Employer: TOWN OF DUXBURY _____

Name of Employee: _____

SS#: _____ Date of Birth: _____

Claim #: _____ Date of Accident: _____

MIA MASSACHUSETTS BASED MEMBER DRIVEN

Member Services
One Federal Street, Boston Massachusetts 02110
Toll Free (Mass) :888/266-6442
Fax: 617 753-9987

WITNESS STATEMENT

INJURED EMPLOYEE NAME: _____

DEPARTMENT: _____ **OCCUPATION:** _____

LOCATION ACCIDENT OCCURRED: _____

Briefly Describe How Injury Occurred: _____

_____

_____

_____

Body Part(s) Involved: _____

_____

Witness Signature: _____ *Date:* _____

Witness name (printed): _____

Witness occupation: _____

Employer _____

Claim number _____

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MIIA Members Services
Workers' Compensation Prescription Information

Employer:
Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	MIIA
MIIA Member:	Town of Duxbury
Employee Name:	
Group#:	10602826
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:
MIIA Members Services has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900