

CITY OF ALVA SAFETY DEPARTMENT

INTERNAL USE ONLY Claim #: \_\_\_\_\_

**CITY OF ALVA - EMPLOYEE INCIDENT REPORT**

EMPLOYEE NAME: \_\_\_\_\_

POSITION: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_ DIVISION: \_\_\_\_\_ INCIDENT

DATE: \_\_\_\_\_ INCIDENT TIME:

\_\_\_\_\_ AM \_\_\_\_\_ PM REPORT DATE:

(If report date is different from incident date, please explain.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This incident involves:

- Employee Injury
- Damage to City Vehicle/Equipment
- Damage to Private Property/Vehicle
- Injury to Someone Other Than a City Employee

1. Location of incident \_\_\_\_\_

2. If injury, (A) What part of your body was injured? \_\_\_\_\_  
(B) What is the extent of your injury? \_\_\_\_\_

(C) Was First Aid administered?  Yes  No

(D) Have you requested medical attention?  Yes  No If Yes, to which Physician, Hospital, or other facility are you going or have already gone?

Physician: \_\_\_\_\_ Location: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

CITY OF ALVA SAFETY DEPARTMENT

3. Explain in detail how this incident occurred. (If more space is needed, attach separate sheet)

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4. Was City Equipment/Vehicle involved? \_\_\_ Yes \_\_\_ No

If Yes, Unit #: \_\_\_\_\_ VIN#: \_\_\_\_\_

Year, Make & Model of vehicle: \_\_\_\_\_

5. If damage to City or Private Property/Vehicle, describe the extent of damage:

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6. Was a Police Report filed? \_\_\_ Yes \_\_\_ No

If yes, reporting agency: \_\_\_ City PD \_\_\_ OK Hwy Patrol \_\_\_ other

7. Were you wearing proper safety equipment (if required) at time of incident? \_\_\_ Yes \_\_\_ No If No, why not? \_\_\_\_\_

8. Was anyone else involved in this incident? \_\_\_ Yes \_\_\_ No

If Yes:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

9. Did anyone else see this incident occur? \_\_\_ Yes \_\_\_ No

If Yes: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

10. In your opinion, were there any unsafe acts or conditions (including people and/or equipment) that caused this incident? \_\_\_ Yes \_\_\_ No

If yes, please explain: \_\_\_\_\_

CITY OF ALVA SAFETY DEPARTMENT

11. In your opinion, how could this incident have been prevented?

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I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete. Any Person who commits Workers' Compensation Fraud, upon conviction, shall be guilty of a felony.

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

Date: \_\_\_\_\_

Employee: Turn this form in to your Supervisor

Supervisor: Submit this form along with your report and any witness/co-worker statements to the Personnel Department and your Department Head within 24 hours of your knowledge of this incident.

Reviewed By: \_\_\_\_\_ (Department Head)  
\_\_\_\_\_ (Personnel)  
\_\_\_\_\_ (City Attorney)  
\_\_\_\_\_ (City Manager)

Comments: \_\_\_\_\_

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# MEDICAL CARE AUTHORIZATION FORM

**Approved First Responder Facility**

**After Hours**

**TO BE COMPLETED BY EMPLOYER**

Employee name \_\_\_\_\_

Nature of Injury \_\_\_\_\_ Body Part(s) \_\_\_\_\_

Date of Injury \_\_\_\_\_ Time of Injury \_\_\_\_\_

Authorized Personnel Signature \_\_\_\_\_ Date: \_\_\_\_\_

Title \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

Post accident drug screen performed? Yes/ No \_\_\_\_\_

O.K. to return to regular duty on \_\_\_\_\_

Return to see me on \_\_\_\_\_

O.K. to work light duty beginning \_\_\_\_\_  
with the following limitations \_\_\_\_\_

**(Note: It is the philosophy of this company to provide modified duty work when possible.)**

Unable to return to work until \_\_\_\_\_

***I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and complete.***

Physician's signature \_\_\_\_\_ Date: \_\_\_\_\_

This authorization applies to initial evaluation only. Any subsequent treatment, diagnostics, DME's or referrals need to be preauthorized by Consolidated Benefits Resources.

**Notice Prescriptions:**

If prescriptions are appropriate, please give the patient a written prescription. Prepackaged prescriptions are not authorized.

**PLEASE FORWARD THE COMPLETED ORIGINAL FORM AND YOUR BILL**

Consolidated Benefits Resources, L.L.C.  
Post Office Box 13770  
Oklahoma City, Oklahoma 73113

405.848.3387 *telephone*  
800. 822.5733 *toll free telephone*  
405.840.4298 *facsimile*      800. 898.6465 *toll free facsimile*

# CC-FORM-2

USE BEGINNING 2/1/14 REGARDLESS OF DATE OF INJURY

Send original to Workers' Compensation Commission and 1 copy to Insurance Carrier

Please type or print. Enter all dates in MM/DD/YY format.

**WORKERS' COMPENSATION COMMISSION**  
1915 NORTH STILES AVENUE  
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

## EMPLOYER'S FIRST NOTICE OF INJURY

Full Name of Employee - LAST, FIRST, MIDDLE		Employee Email Address	
Complete Address	City	State	Zip
Telephone Number	Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____		
Date of Birth	Sex	Length of Employment: Years _____ Months _____	
Average Weekly Wage		Occupation (job description)	Date of Hire: _____
			Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

Date of accident or last exposure	Time of accident or exposure o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>	Date Employer Notified	Time workday began o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>
Last date employee worked	Has employee returned to work? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date? _____	Did the employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date? _____	
OSHA Log Case #	Place of Accident or Occurrence City: _____ County: _____ State: _____		
Injury Resulted from: Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/> Occupational Disease <input type="checkbox"/>			
Nature of Injury or Illness		Does employee participate in a certified workplace medical plan: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, name of CWMP: _____	
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.			
Identify part(s) of body involved in injury or illness			
Full Name and address of Treating Physician (please be complete)			
Employer's Insurance Carrier or Own Risk Group <b>CompSource Okla. (OMAG Retention Work Comp Plan)</b>		Policy/Self-Insured Number	
Name <b>Consolidated Benefits Resources, LLC</b>	Phone <b>(405) 848-3387</b>	Policy Period: From _____ To _____	
Address <b>PO Box 13770</b>	City <b>Oklahoma City</b> State <b>OK</b> Zip <b>73113</b>	Client #	
Employer's Name and Complete Address		Client Number: _____	Location: _____
Name	Federal ID#	Phone #	Department:
Address	City	State	Zip
Type of business (Example: manufacturing, food service, construction)			NAICS Number
Type of Ownership: Private <input type="checkbox"/> State Government <input type="checkbox"/> County Government <input type="checkbox"/> Local Government <input type="checkbox"/>			

**Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a):** "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

**Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.**

The undersigned hereby declares under PENALTY OF PERJURY that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this CC-Form 2 was sent to the Workers' Compensation Commission and a copy thereof to the employer's insurer on the date noted below:

Signed \_\_\_\_\_  
Signature of Preparer

By \_\_\_\_\_  
Name and Title of Preparer (Please Print)

Telephone Number \_\_\_\_\_  
Area Code and Number

Date \_\_\_\_\_

**A CC-Form 2 must be sent to the Workers' Compensation Commission and to the employer's workers' compensation insurance carrier within 10 days after the date of receipt of notice or knowledge of death or injury that results in more than three days' absence from work for the injured employee.**

**PROVIDING THIS FORM TO THE COMMISSION IS NOT EVIDENCE OF ANY FACT STATED IN THE REPORT IN ANY PROCEEDING WITH RESPECT TO THE INJURY OR DEATH ON ACCOUNT OF WHICH THE REPORT IS MADE.**



## Injured Worker First Fill Prescription Form\*

*To be filled out by employer and given to injured worker*

Please **PRINT** the following information: (\*Required Fields)

Last Name:	First Name:	Date of Birth:
*Social Security Number: XXX-XX- (last four digits)	*Date of Injury:	Type of Injury:
Employer's Name:	Employer's Phone #:	Body Part Injured:
*Employer's Signature Authorizing Prescription:		Date:

### Injured Worker Instructions: (\*For New Injuries Only)

**Present this form to the Pharmacy; No co-pay will be required.**

- On your first visit to a network pharmacy, please give this form and written prescription to the pharmacist to expedite the processing of your approved Workers' Compensation prescriptions.
- Approved prescriptions are based on the parameters established by **Consolidated Benefits Resources**. Please contact your pharmacy for refills.
- If your local Pharmacy is not listed below, please call 1-800-758-5779 to locate a participating pharmacy near you or go to [www.healthsystems.com](http://www.healthsystems.com).

#### Sample of Healthsystems Network Pharmacies

Albertsons	CVS	Indian Health Center	Med-X Drug	Sooner Pharmacy
Apothecary Shoppe	Dons	Kens	NCS Healthcare of OK	Target
Buy for Less	Drug Mart	Kmart	Palace Drug	United Supermarkets
Central Drug	Drug Warehouse	Mays Drug Store	Pratts Pharmacy	United Discount Drug
City Market	Eckerd	Medical Center Phar	Professional Pharmacy	Walgreens
Clinic Pharmacy	Family Meds	Medicap Pharmacy	R&S Drug	Wal-Mart
Couch Pharmacy	Homeland	Medicine Chest	Reasors Pharmacy	Western Drug
Crest Discount Phar	IHS	Medicine Shoppe	Sam's Club	Winn Dixie

### Pharmacist Instructions:

Your company has a contract to participate in the Healthsystems Pharmacy Network.

- **To dispense the patient's "First-Fill", please call Healthsystems at 1-800-758-5779.**
- **Please indicate to the Healthsystems Help Desk this is a new injury.**  
*Please do not process under an existing injury. Thank you for your assistance.*

BIN# 012874



**Temporary Member ID  
(Pharmacist Use Only)**



## Mandatory Medicare Reporting Requirement

\*\*\*\*\* Please complete this form with each report of injury\*\*\*\*\*

Medicare now requires mandatory reporting of Workers' Compensation claims. The purpose of the reporting process is to enable Centers for Medicare & Medicaid Services (CMS) to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer.

To be completed by the employee (Please print)

Date: \_\_\_\_\_

Injured Worker Name: \_\_\_\_\_  
(Name as it appears on your social security card)

Social Security Number: XXX-XX-\_\_ \_\_ \_\_ \_\_

Dear Injured Worker, please provide an answer to the following questions:

YES NO

<input type="checkbox"/>	<input type="checkbox"/>

Are you currently on SSDI? (Social Security Disability)

Have you ever applied for SSDI?

Do you anticipate filing for SSDI within the next 30 months?

Are you a Medicare beneficiary?

Do you anticipate filing for Medicare benefits in the next 30 month?

Signature of Injured Worker

Date

PLEASE FORWARD THE COMPLETED FORM TO:

CONSOLIDATED BENEFITS RESOURCES, L.L.C.  
Post Office Box 13770  
Oklahoma City, Oklahoma 73113  
405.848.3387 telephone  
800. 822.5733 toll free telephone  
405.840.4298 facsimile  
800. 898.6465 toll free facsimile

Consent for Release of Protected Health Information

OMAG

I, \_\_\_\_\_ (Circle) Patient, Parent, Guardian, legal custodian of:

\_\_\_\_\_  
(NAME OF PATIENT) SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name of individual/company to receive PHI:

Name of individual/company to disclose PHI:

Workers' Compensation Claims  
Consolidated Benefits Resources, LLC.  
P.O. Box 13770  
Oklahoma City, Oklahoma 73113

\_\_\_\_\_  
\_\_\_\_\_

Information authorized for use or disclosure, or to be obtained:

- All medical information concerning this patient.
- Medical information of this patient compiled between the dates of \_\_\_\_\_ and \_\_\_\_\_.
- Only: \_\_\_\_\_

The information will be obtained, used and/or disclosed for the following purpose(s) only:

- Insurance  Continued treatment  Legal  At the request of the patient or patient's representative
- Workers' Compensation Benefits  Other (specify) \_\_\_\_\_

Date Authorization expires: \_\_\_\_\_ (if no date is selected, this Authorization will expire in one (1) year from the date signed below).

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation to Claims Manager of Consolidated Benefits Resources, LLC.
- I release the entities listed above, their agents and employee from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will be compensated by the recipient for the disclosure, except for the cost of copying and mailing as permitted by law.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse confidentiality requirements.
- I have the right to inspect the health information to be released and I may refuse to sign this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.

The information I authorize for release may include records which may indicate the presence of a communicable or noncommunicable disease, or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I further understand that my medical information may indicate that I have been treated for psychological or psychiatric conditions or substance abuse.

\_\_\_\_\_  
Signature of Patient or Representative Date

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Representative's Relation to Patient

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
Signature of Witness Date

\_\_\_\_\_  
Date Authorization expires

Notice of Rights: Information in your medical records that you have or may have a communicable or noncommunicable disease or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have risk exposures, disclosure pursuant to order of a court or the Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, or by an order of a court or the Department of Health.

A COPY IS AUTHORIZED AS AN ORIGINAL

# Occupational Injury or Illness Report

*This form contains sections to be completed by both the supervisor and the employee.*

The accident should be investigated by the supervisor of the injured employee or department involved. It should be completed soon as possible to obtain the most accurate information.

Supervisor Section					
Date of Injury:		Date Reported:		Employer Name:	
Name of Employee:			S.S. No:	XXX-XX- (last four digits)	
Home Address:					
Home Phone:		Work Ext:	Date of Birth:		
Cell Phone:					
Sex:	Occupational Title:		Date of Employment:		
Time Work Shift Began:		Time Accident Occurred:		Day of week	
AM/PM		AM/PM		M T W TH F S SU	
Location:					
Injury Type (Circle)					
25	Foreign Body in Eye	81	Animal, Insect, Human Bite	28	Fracture
43	Cut/Puncture	46	Hernia/ Rupture	02	Amputation
40	Abrasion/Scratches	99	Heart Attack/Stroke	68	Skin Irritation/ Dermatitis
10	Bruise/Contusion/Crushing	72	Hearing Impairment	07	Concussion/ Loss of Consciousness
49	Sprain/Strain	66	Exposure (Chem. Temp. Elect)	24	Death
04	Burn (Chem, Liquid, Electrical)	81	Exposure (Blood/ Body Fluid)	00	Other
Injury Cause (Circle)					
46	Struck by/ Against Object	31	Noise	85	Animal, Insect, Human
25	Fall-Same Level, Different Level	98	Repetitive Motion/Trauma	84	Hot Object, Substance or Fire
54	Jumping or Climbing	30	Slipping/Tripping	26	Caught in/Under/ Between
48	Vehicle Accident/ Struck by Vehicle	57	Pushing/Pulling/ Lifting/ Carrying	59	Other
Was injury caused by another person, faulty/broken equipment, a vehicle?				Yes	No
If yes, explain:					
Body Part Injured (Circle)					
02	Head/Neck/Face/Mouth	44	Wrist (Left Right)	74	Hips/ Buttocks
05	Eye (Left Right)	45	Hand (Left Right)	46	Fingers (Left Right) Digit:
04	Ear (Left Right)	61	Back (Upper Lower)	83	Knee (Left Right)
48	Shoulder (Left Right)	67	Chest/Abdomen Including internal organs	85	Ankle (Left Right)
41	Arm (Left Right)	66	Pelvis/ Groin	86	Foot (Left Right)
42	Elbow (Left Right)	82	Leg (Thigh Calf)	87	Toes (Left Right) Digit:
73	Respiratory	01	Other	96	No Physical Injury
First Aid or Medical Treatment					
Was first aid given?		Yes	No	If yes, by whom:	
Was medical treatment required by a physician or hospital?				Yes	No
Physician/ Hospital Name, Address, and telephone number:					

Explanation of injury ( How, When, Where)

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Date you first noticed the pain? \_\_\_\_\_ Did this pain develop gradually?  Or suddenly?

If the pain developed suddenly, exactly what were you doing when the pain was felt?

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If nothing unusual or unexpected happened, what do you think caused the pain?

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List body parts injured:

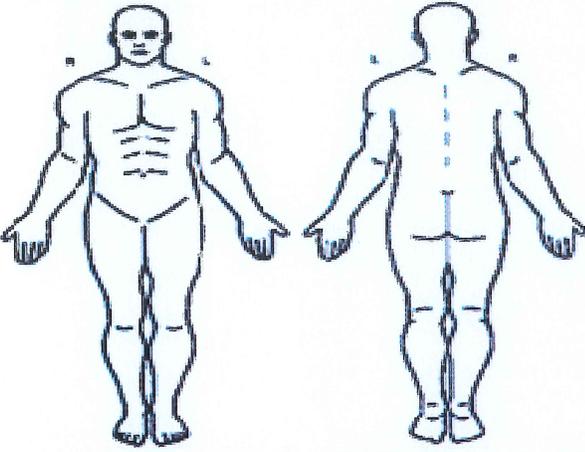
Have you discussed this pain with anyone at work? If yes, with whom and when?      Yes    No

Have you had any recent non-work related injuries/illnesses? If yes, please list:      Yes    No

If the above answer is yes, what was the problem, when did it occur, and what (if any) medical treatment did you receive?

**Show part(s) of the body injured, noting the longevity, type and degree of pain.**

On the diagram below, indicate the location, description, and level of pain you are experiencing at this time.  
 Example: "A-6= Ache- Severe pain"

	<b>Note type of pain:</b>		
	A = Ache	B = Burning	P = Pins & Needles
	N = Numbness	S = Stabbing	O = Other
	<b>Note level of pain:</b>		
	0	No Pain	
	1	Mild pain, you are aware of it, but it doesn't bother you	
	2	Moderate pain that requires medication to tolerate the pain	
3	More severe pain		
4	Severe pain		
5	Intensely severe pain		
6	Most severe pain, unbearable		
<b>Was medical treatment away from the job site offered?</b>			
Yes	No		

If treatment was offered, but declined, please sign:

Have you ever received medical treatment for the injured body part(s) listed above? If so, please note the date and physician/hospital where treatment was rendered.	Yes	No	
Are you currently receiving Social Security <b>Disability</b> Payments ( <i>not Social Security retirement payments</i> )?	Yes	No	
Are you currently receiving Medicare assistance?	Yes	No	

**I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief they are correct and complete.**

<b>Employee Name: (Print)</b>		<b>Date:</b>
<b>Employee Signature:</b>		

**Supervisor's Statement**

As a result of your investigation, what do you believe occurred and why?

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From your investigation is the validity of the accident in doubt?    Yes    No    If yes, explain why.

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Was a third party at fault? If yes, explain

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Were there any witnesses? If yes, please list

Name	Address	Phone	Date

**Supervisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_