

**Resolution 2010-04**

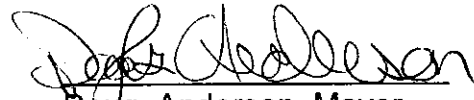
A Resolution to amend the select provider program

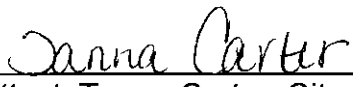
**WHEREAS**, Buffalo City Council sets City policy

**WHEREAS**, it is in the best interest for the City of Buffalo and in order to meet recommendations set forth by EMC Insurance provider.

**WHEREAS**, the City of Buffalo adopted the Select provider program resolution #2010-2

**NOW THEREFORE BE IT RESOLVED**, by the Buffalo City council that the City hereby amends the Select Provider Program as described in attached exhibit A.

  
Doug Anderson, Mayor

  
Attest: Tanna Carter, City Clerk

# ATTENTION ALL EMPLOYEES

## CITY OF BUFFALO Workers' Compensation Medical Treatment Change

EFFECTIVE March 1, 2010

**If you are injured at work, you must immediately report the incident to your supervisor.**

CITY OF BUFFALO has made a change in how ALL work related injuries/illnesses should be treated. The following medical facilities are the designated workers' compensation treatment centers.

If you need medical treatment due to a work related injury or illness, seek treatment at:

PHYSICIAN/CLINIC	ADDRESS	PHONE	HOURS
GENESIS OCCUPATIONAL HEALTH	3319 Spring Street, Suite 103 Davenport, IA 52807	(563) 324-0696	8:00 am – 5:00 pm (Mon - Fri)

For A SERIOUS INJURY OR ILLNESS (or any treatment that should not wait until clinic hours the next day) seek immediate treatment at the nearest emergency facility. Hospitals included (but not limited to):

HOSPITAL	ADDRESS	PHONE	HOURS
GENESIS MEDICAL CENTER, WEST CENTRAL PARK	1401 West Central Park Davenport, IA 52804	(563) 421-6000	24 HOUR SERVICE

### Please Note

If you choose to be treated by any other medical facility and/or physician after March 1, 2010, you may not qualify for any workers' compensation insurance benefits and you may be responsible for all medical costs related to this incident. This is in accordance with your state's Workers' Compensation statute.

If you have any questions regarding this procedure, please call Tanna Carter at (563) 381-2226.

\_\_\_\_\_  
Employee's Signature (PRINTED)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Signature

 **EMC.**  
Insurance Companies

You are responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This will make the processing of your claim both accurate and timely. This completed report should be given to the workers' compensation contact within 24 hours of your work-related injury.

## Employee's Work Injury Report

**Personal**

Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Address \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex M  F   
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Married  Single  Number of dependents \_\_\_\_\_ Home/School \_\_\_\_\_  
Family Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Are you currently entitled to Medicare Benefits? N\_\_ Y\_\_ Medicare #(HICN) \_\_\_\_\_  
Have you applied for Medicare or SSDI? N\_\_ Y\_\_ Pending \_\_\_ Rejected \_\_\_

**Employment**

Job Title \_\_\_\_\_ Employment Date \_\_\_\_\_  
Salary/Hourly Rate \_\_\_\_\_ Hours Worked Per Day \_\_\_\_\_  
Building Location \_\_\_\_\_ Time Work Day Begins \_\_\_\_\_

**Injury/Illness**

Date of Injury \_\_\_\_\_ Time of Accident? \_\_\_\_\_  
Where in the facility/job site did this injury occur? \_\_\_\_\_  
What were you doing when injured? \_\_\_\_\_  
How did the injury occur? \_\_\_\_\_  
Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate.) \_\_\_\_\_  
Any previous similar injury? If yes, explain \_\_\_\_\_  
Was this injury witnessed? If so, by whom? \_\_\_\_\_  
Did you lose time from work? Yes  No  Date(s) missed? \_\_\_\_\_  
Have you returned? \_\_\_\_\_ If yes, what was the date? \_\_\_\_\_

**Treatment**

Medical Facility? \_\_\_\_\_  
Diagnosis/Care Prescribed? \_\_\_\_\_

**Contact**

When you return to work, you must call Tanna Carter at (563) 381-2226 .

Employee's Signature (PRINTED) \_\_\_\_\_ Date \_\_\_\_\_  
Employee's Signature \_\_\_\_\_

# SUPERVISORS INVESTIGATION REPORT

Name of Injured Employee	Date
Job Title and Department	
Date and Time of Injury	Type of Injury
Medical Facility	

What was the employee doing when injured? Where in the facility/job site did the accident happen?

\_\_\_\_\_

Describe what happened: \_\_\_\_\_

\_\_\_\_\_

What corrective steps will be done (or could be done) to prevent recurrence? \_\_\_\_\_

\_\_\_\_\_

Was the employee working at designated job? Yes  No

Is there modified duty available for the injured worker? Yes  No

Has the injured employee returned to work? Yes  No  If so, what date? \_\_\_\_\_

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by Workers' Compensation Contact

\_\_\_\_\_  
Date

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

\_\_\_\_\_

**Return completed form within 24 hours of the accident to Tanna Carter at (563) 381-2226.**

# **SUPERVISOR'S INSTRUCTIONS**

## **Assisting the Injured Employee**

1. An employee who is injured at work must immediately report the incident to their supervisor.
2. The supervisor is required to:
  - Obtain immediate medical attention for the injured worker: Call the physician or medical facility prior to the employee's arrival, alert the staff of the injury/illness and approximate arrival time;
  - Follow company requirement for reporting job related injuries and illnesses;
  - Complete an incident investigation report.
3. The supervisor and injured worker review information received from the doctor and jointly determine if appropriate work is available.
4. Following an injured workers' return to work, the supervisor or the workers compensation contact monitors the injured workers' progress to assure that restrictions are carefully followed and assist to resolve any difficulties.
5. The injured worker must immediately report any difficulties with performing assigned work. Supervisor and injured worker work to address the problem.

## **The Investigation Report**

The purpose of this form is to determine what actions are needed to eliminate or control the hazards that have caused the accident. The information gathered will guide your staff in developing safety consciousness and knowledge of safe conditions and safe work methods. If you are not aware of the circumstances surrounding the injury, you should consult with the employee in order to complete the investigation report accurately.

The statements made in this report are very important and should not contain phrases as "Employee should be more careful." As the supervisor, you should make the appropriate corrective recommendations for each accident such as "Notified the appropriate employee to place caution signs in the area when floors are wet."

After you complete the investigation report, return it to the workers' compensation contact within 24 hours of the employee's work-related injury.

If you have any questions or concerns, call Tanna Carter at (563) 381-2226.

# PHYSICIAN AUTHORIZATION FORM FOR MEDICAL TREATMENT

Injured Employee's Name:	Date
Company Name & Address CITY OF BUFFALO 329 Dodge Street Buffalo, IA 52728	Supervisor

**Do Not Use Your Group Health Membership Card** if this injury/illness was sustained while working or acting in an official capacity for this company.

The following facilities are the designated workers' compensation treatment centers. Taking this Physician's Authorization Form with you will assist the staff in your care and in processing your medical bills correctly. You should call or have someone call for you to let the physician or clinic know you are on your way for medical treatment and the nature of the injury or illness.

PHYSICIAN/CLINIC	ADDRESS	PHONE	HOURS
<b>GENESIS OCCUPATIONAL HEALTH</b>	3319 Spring Street, Suite 103 Davenport, IA 52807	(563) 324-0696	8:00 am – 5:00 pm (Mon - Fri)

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If you have any questions regarding this procedure, please call Tanna Carter at (563) 381-2226.

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

# Work-Related Injury/Illness Report

Date of Service: \_\_\_\_\_

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

Employer: CITY OF BUFFALO

**PLEASE FAX IMMEDIATELY TO BOTH:**

City of Buffalo FAX: (563) 381-4759

EMC Insurance Companies FAX: (515) 345-2118

Notified: Yes  No

Diagnosis: \_\_\_\_\_ Is condition work related? Yes  No

Treatment Plan: \_\_\_\_\_

Medication(s): \_\_\_\_\_

Date of most recent examination by this office: \_\_\_/\_\_\_/\_\_\_ . The next scheduled visit is:  as needed  
Month/Day/Year

OR \_\_\_/\_\_\_/\_\_\_  
Month/Day/Year

1.  Recommended his/her return to work with no limitations on \_\_\_\_\_ Date
2.  He/She may return to work on \_\_\_\_\_ Date with the following limitations.

Degree	Limitations												
<input type="checkbox"/> <b>Sedentary Work.</b> 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.	1. In an 8 hour work day, patient may: <ul style="list-style-type: none"> <li>a. Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 6-8 Hours</li> <li>b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours</li> <li>c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours</li> </ul> 2. Patient may use hands for repetitive: <ul style="list-style-type: none"> <li><input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing &amp; Pulling</li> <li><input type="checkbox"/> Fine Manipulation</li> </ul> 3. Patient may use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No												
<input type="checkbox"/> <b>Light Work.</b> 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 is 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.	4. Patient is able to: <table style="width: 100%; border: none;"> <tr> <td style="text-align: left;">Frequently</td> <td style="text-align: center;">Occasionally</td> <td style="text-align: center;">Not at all</td> </tr> <tr> <td>a. Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Frequently	Occasionally	Not at all	a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	c. Climb	<input type="checkbox"/>	<input type="checkbox"/>
Frequently	Occasionally	Not at all											
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>											
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>											
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>											
<input type="checkbox"/> <b>Medium Work.</b> Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.													
<input type="checkbox"/> <b>Heavy Work.</b> Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.													
<input type="checkbox"/> <b>Very Heavy Work.</b> Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.													

## Other Instructions and/or limitations:

3. These restrictions are in effect until \_\_\_\_\_ Date or until patient is reevaluated.
4.  He/She is off work at this time. Patient will be reevaluated on \_\_\_\_\_ Date

Treating Facility Name: \_\_\_\_\_  
please print

Physician's Signature: \_\_\_\_\_ Phone No: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

### Release of Information Authorization

I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_