Employee Injury/Illness Reporting

Any employee or volunteer who sustains a bodily injury or illness in the course and scope of their position at the City of Port Washington is to report it to their immediate supervisor and through their supervisor to HR as soon as possible, but no later than within 24-hours of the incident, injury, or onset of symptoms (serious injuries must be reported within two hours).

Your health and safety are always paramount – in emergency situations, please do the following:

1. Seek medical treatment first.
    a. Determine the extent and nature of the injury or illness.
    b. See that proper first aid is administered.
    c. Activate EMS (911), if necessary.
2. Report the Incident:
    a. The employee will be responsible to report the incident, injury, or illness by completing and signing an **Employee Injury/Illness Report Form** in its entirety and returning it within 24 hours to the HR Generalist, hr@portwashingtonwi.gov.
    b. If medical attention is needed, the employee should have the **Return to Work Form** completed by the attending physician.

For minor injuries requiring no medical treatment or only basic first aid, the employee should make an entry in the **First Aid Log**, which supervisors will have on file.

Failure to report an injury or illness to HR, by either the injured employee or their supervisor, may result in disciplinary action up to and including termination.

Supervisors are responsible for completing and signing the corresponding Supervisor Investigation of Injury/Illness for each Employee Injury or Illness Report Form.

Once the Employee Injury/Illness Report Form is completed, it shall be forwarded to Human Resources within 48 hours so the required WKC-12 form can be generated and sent to the City of Port Washington Insurance carrier.

January 2025

EMPLOYEE INJURY/ILLNESS REPORT FORM APPENDIX A

Employee Name (First, Middle, Last)	Sex ☐ M ☐ F	Employee Home Telephone No. ( )

Employee Home Street Address	City	State	Zip Code	Occupation

Birth Date	Date of Hire	County and State where incident or exposure occurred

Injury Date Mo / Day / Yr	Time of Injury ☐ am ☐ pm	Last Day Worked Mo / Day / Yr	Date Employer Notified Mo / Day / Yr	Shift working at time of incident (i.e., 7:00 – 4:00)	☐ Did you leave work? ☐ Estimated Date of Return

Hours worked prior to injury	Location where injury occurred – be as specific as possible.

Were you or do you anticipate being treated by a medical professional for this injury or illness? ☐ Yes ☐ No

Were you hospitalized for this injury or illness? ☐ Yes ☐ No

Name and address of medical professional and/or hospital:

AREA INJURED

1 ☐ **Head**	9 ☐ **Finger: Specify**	15 ☐ **Knee** L ☐ R ☐
2 ☐ **Eye** L ☐ R ☐		16 ☐ **Ankle** L ☐ R ☐
3 ☐ **Back**	10 ☐ **Chest**	17 ☐ **Foot** L ☐ R ☐
4 ☐ **Shoulder** L ☐ R ☐	11 ☐ **Abdomen**	18 ☐ **Toe: Specify**
5 ☐ **Arm** L ☐ R ☐	12 ☐ **Pelvis**	
6 ☐ **Elbow** L ☐ R ☐	13 ☐ **Hip** L ☐ R ☐	19 ☐ **Other**
7 ☐ **Wrist** L ☐ R ☐	14 ☐ **Leg** L ☐ R ☐	
8 ☐ **Hand** L ☐ R ☐		

TYPE OF INJURY

1 ☐ **Abrasion**	7 ☐ **Cut / Laceration**	13 ☐ **Puncture**
2 ☐ **Amputation**	8 ☐ **Foreign Body**	14 ☐ **Rash / Dermatitis**
3 ☐ **Bite**	9 ☐ **Fracture**	15 ☐ **Respiratory**
	10 ☐ **Hearing Impaired**	16 ☐ **Strain / Sprain**
4 ☐ **Bruise**	11 ☐ **Infection**	17 ☐ **Other**
5 ☐ **Burn**	12 ☐ **Pain**	
6 ☐ **Concussion**		

Employee Account of Injury: Describe your activities when injury or illness occurred and what tools, machinery, objects, chemicals, etc. were involved.

What happened to cause this injury or illness? (Describe how the injury occurred).

Describe your injury or illness. (State the part of body affected and how it was affected).

In your opinion, list the ways a similar occurrence could be prevented in the future. (e.g., equipment, training, procedures, etc.)

☐ Additional Page(s) attached.

Witness(es) – Names of all employees and non-employees who witnessed your injury or illness. (Use additional page if necessary).

Employee Signature:	Date Signed
Supervisor Signature:	Date Signed

EMAIL INJURY REPORT TO: hr@portwashingtonwi.gov

APPENDIX I

RETURN TO WORK FORM

Injury is: ☐ work related ☐ non-work related Date of Injury/Illness:

Patient's Name (Last) (First) (Middle Initial)

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis:

I saw and treated this patient on _____/_____/_____ and based on the above description of the patient's current medical problem:

1. He/She/They is totally incapacitated at this time. Patient will be re-evaluated on _____/_____/_____ Date
2. Recommended his/her return to work with no limitations on _____/_____/_____ Date
3. He/She/They may return to work on _____/_____/_____ with the following limitations: Date

CHECK ONLY AS RELATES TO ABOVE CONDITION(S)

☐ **SEDENTARY WORK:** Lifting 10 pounds maximum & 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.

☐ **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 involved sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **LIGHT MEDIUM WORK:** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **MEDIUM WORK:** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **LIGHT HEAVY WORK:** Lifting 75 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **HEAVY WORK**: Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

PLEASE CIRCLE:

1. In an 8-hour work day patient may:

   Stand or walk 1 2 3 4 5 6 7 8 hours, or (unrestricted)

   Sit 1 2 3 4 5 6 7 8 hours, or (unrestricted)

   Drive 1 2 3 4 5 6 7 8 hours, or (unrestricted)

2. Patient may use hand(s) for repetitive:

   Single Grasping Pushing and Pulling

   Fine Manipulation

3. Patient may use foot/feet for repetitive movement as in operation of foot controls: Yes [ ] No [ ]

4. Patient may:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY
a. Bend	[ ]	[ ]	[ ]
b. Twist	[ ]	[ ]	[ ]
c. Squat	[ ]	[ ]	[ ]
d. Climb	[ ]	[ ]	[ ]
e. Reach	[ ]	[ ]	[ ]

OTHER INSTRUCTIONS AND/OR LIMITATIONS INCLUDING PRESCRIBED MEDICATIONS

The restrictions are in effect until _____or until patient is re-evaluated on _____/_____/_____ _____AM PM
Date Time

Referred to: Private Physician _____
A Consultant _____

Physician's Signature _____ Date: _____/_____/_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my attending physician and/or hospital to release any information or copies thereof acquired in the course of any examination or treatment for the injury identified above to my employer or his representative.

Patient's Signature _____ **Date** _____

APPENDIX J

EMPLOYEE INJURY/ILLNESS REPORTING PROCESS