

## EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

<b>Are you seeking medical treatment?</b> <input type="checkbox"/> Yes, Continue with this form <input type="checkbox"/> No, Complete and submit an Employee First Aid Report			
<b>EMPLOYEE: All blocks must be completely filled out</b>			
Name: Last		First	
Mailing Address		Date of Birth	Date of Death (If applicable)
City	State	Zip Code	Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U
Telephone No. Primary	Telephone No. Alternate		Marital Status <input type="checkbox"/> M-Married <input type="checkbox"/> S-Separated <input type="checkbox"/> U-Unmarried <input type="checkbox"/> K-Unknown
Date of Injury / Illness	Time of Injury / Illness		Number of Dependents
Describe Part of Body Affected (i.e., left lower leg, right index finger, etc.)		Employer <input type="checkbox"/> Borough <input type="checkbox"/> School District	Department / School Location
Describe Nature of Injury / Illness (i.e., sprain, laceration, etc.)		Union Affiliation	Supervisor's Name
Was This An Assault? (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No		Occur on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisor's Contact Number
Definition of an assault: Any willful attempt or threat to inflict injury upon the person of another, when coupled with an apparent present ability to do so, and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm.			
Describe How the Injury / Illness Happened			
Witness Name / Contact Number		Witness Name / Contact Phone Number	
Initial Treatment <input type="checkbox"/> Minor Clinic/Hospital Remedies and Diagnostic Testing <input type="checkbox"/> Emergency Evaluation, Diagnostic Testing, and Medical Procedures <input type="checkbox"/> Hospitalization Greater than 24 Hours <input type="checkbox"/> Future Major Medical/Lost Time Anticipated		Physician Name	
		Medical Facility Name	
<b>Employee Authorization to Release Medical Records</b> <b>To all health care providers:</b> You are authorized to provide my employer, its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature. I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.			
Employee Signature/Digital Signature/Print:		Date Signed:	
If Employee Unavailable to sign, Explain Circumstances in this Space			Date Signed

**WARNING TO EMPLOYEES AND EMPLOYERS:** AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

ORIGINAL TO RISK MANAGEMENT IMMEDIATELY & NOTIFY SUPERVISOR

EMPLOYEE KEEP A COPY

**EMPLOYER:** File the complete First Report of Injury (FROI), form 07-6101, with the Alaska Division of Workers' Compensation by electronic data interchange (EDI), or by mail, within 10 days of receiving this report, per AS 23.30.070(a).

EMPLOYEES SEND COMPLETED FORMS TO:

**EMAIL:** [ReportClaims@fnsb.gov](mailto:ReportClaims@fnsb.gov)

**MAIL TO:**

**Fairbanks North Star Borough Risk Management**

**P.O. Box 71267 Fairbanks, AK 99707**

**FAX: (907) 459-1187**

**HAND DELIVER: 907 Terminal Street, 3<sup>rd</sup> Floor, Risk**

**Interoffice or mailbag address: FNSB/Risk Mgt.**

Claims Adjuster Use Only



# FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT FITNESS FOR DUTY

Non-work related injury or illness

Workers' Compensation

*Note to Supervisor and Employee:* Employee is not allowed back on the job site until this form has been reviewed and approved for return to work. Human Resources will contact the supervisor to facilitate the review and approval process. **Fax this form to (907) 451-6008 or hand-deliver form to Human Resources.**

*Note to Supervisor and Employee:* Treating employee is not allowed back to duty until Risk Management has reviewed and approved their return to work. The Claims Adjuster will contact the supervisor to facilitate the review and approval process. **Fax completed form to (907) 459-1187 or hand deliver to FNSB Risk Management within one day of your appointment.**

## Employee Work Status (Fitness for Duty)

**Employee Name:** \_\_\_\_\_

- Unable** to return to work until \_\_\_\_\_
- Can return to **full work** with no restrictions on: \_\_\_\_\_ (Please mark restrictions below)
- Can return to **modified work** on: \_\_\_\_\_ adhering to **restrictions** checked below:

### Physical Capacity Restrictions

**All sections must be completed by treating physician**

NOTE: **OCCASIONALLY** (UP TO 2 HOURS PER 8-HOUR DAY) **FREQUENTLY** (UP TO 4 HOURS PER 8-HOUR DAY)

<b>Lift/Carry</b>	<u>Not At All</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>No Restrictions</u>
0 – 3 lbs.	_____	_____	_____	_____
4 - 10 lbs.	_____	_____	_____	_____
11 - 20 lbs.	_____	_____	_____	_____
21 - 40 lbs.	_____	_____	_____	_____
Over 40 lbs.	_____	_____	_____	_____
<b>Able To Do</b>				
Bending	_____	_____	_____	_____
Squatting	_____	_____	_____	_____
Climbing	_____	_____	_____	_____
Pushing/Pulling	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____
Reach above shoulder	_____	_____	_____	_____
Repetitive hand motion	_____	_____	_____	_____
Stand	_____	_____	_____	_____
Walk	_____	_____	_____	_____
Sit	_____	_____	_____	_____
Drive	_____	_____	_____	_____

\_\_\_\_\_ Keep wound/dressing clean & dry

\_\_\_\_\_ Use assistive devices: sling, brace, crutches

\_\_\_\_\_ Avoid contact with chemicals

\_\_\_\_\_ can do data entry \_\_\_\_\_ hours at a time

Other \_\_\_\_\_

Describe how any prescribed medications would adversely affect the performance of essential job functions:

\_\_\_\_\_ Follow-Up Care

\_\_\_\_\_ Final visit, discharge from care for this injury/illness Re-Evaluation on \_\_\_\_\_

\_\_\_\_\_ Physical Therapy prescribed: Frequency \_\_\_\_\_ Duration \_\_\_\_\_

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

Physician Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Human Resources' Signature: \_\_\_\_\_ Date: \_\_\_\_\_