MN Department of Labor and Industry
Workers' Compensation Division
(651) 284-5032 or 1-800-342-5354

First Report of Injury

See Instructions on Reverse Side

Print in ink or type
Enter dates in MM/DD/YYYY format

DO NOT USE THIS SPACE

1. EMPLOYEE SOCIAL SECURITY # | 2. OSHA case # | 3. Time employee began work on date of injury ☐ am ☐ pm

4. DATE OF CLAIMED INJURY | 5. Time of injury ☐ am ☐ pm | 6. Date of death | # of dependents (if death is related to injury)

7. EMPLOYEE Name (last, suffix, first, middle) | 8. Gender ☐ M ☐ F | 9. Marital status ☐ Married ☐ Unmarried

10. Home address | 11. Home phone # | 12. Date of birth | 13. Date hired

City | State | Zip Code | 14. Occupation | 15. Regular department | 16. Apprentice ☐ Yes ☐ No

17. Average weekly wage | 18. Rate per hour | 19. Hours per day | 20. Days per week | Normal work schedule Sun - Sat S M T W T F S | 21. Employment status (check all that apply) ☐ Full time ☐ Part time ☐ Seasonal ☐ Volunteer

22. **Tell us how the injury/illness occurred, what the employee was doing before the incident (give details), and what the injury/illness was.** *Examples: "Worker was driving lift truck with a pallet of boxes when the truck tipped, pinning worker's left leg under drive shaft." "Worker developed soreness in left wrist over time from daily computer key entry."*

23. **What was the injury or illness (include the part(s) of body)?** *Examples: chemical burn left hand, broken left leg, carpal tunnel syndrome in left wrist.*

24. **What tools, equipment, machines, objects, or substances were involved?** *Examples: chlorine, hand sprayer, pallet lift truck, computer keyboard.*

25. Did injury occur on employer's premises? ☐ Yes ☐ No
Name and address of the place of the occurrence

26. Date of first day of any lost time

27. Employer paid for lost time on day of injury (DOI) ☐ Yes ☐ No ☐ No lost time on DOI

28. Date employer notified of injury

29. Date employer notified of lost time

30. Return to work date

31. RTW same employer ☐ Yes ☐ No

32. RTW with restrictions ☐ Yes ☐ No

33. Treating physician (name)

34. Extent of medical treatment (check all that apply)
☐ None ☐ Minor on-site by employer's medical staff ☐ Minor clinic/hospital
☐ Emergency room ☐ Hospitalization more than 24 hours
☐ Future major medical anticipated

35. Certified Managed Care Organization (if any)

36. **EMPLOYER** Legal name
RENVILLE COUNTY

37. **EMPLOYER DBA** name (if different)

38. **Mailing** address
105 S 5TH STREET, SUITE 315

39. Employer FEIN
41-600588

40. Unemployment ID #

City: OLIVIA | State: MN | Zip Code: 56277

41. Employer's contact name and phone #
HR COORDINATOR, 320-523-3753

42. **Physical** address (if different)

43. Witness (name and phone) - if more than 1 attach a separate sheet

City | State | Zip Code

44. NAICS code

45. Date form completed

46. **INSURER** name
MN COUNTIES INTERGOVERNMENTAL TRUST

51. **CLAIMS ADMIN COMPANY (CA)** name (check one) ☑ Insurer ☐ TPA
MCIT

47. Insured legal name and FEIN

52. CA address
100 EMPIRE DR SUITE 100

48. Policy # (including effective dates) or self-insured certificate #

City: ST PAUL | State: MN | Zip Code: 55103

49. Insurer FEIN

50. Date insurer received notice

53. CA FEIN

54. CA claim #

55. To be completed by the CA: | Claim type code: | Type of loss code: | Late reason code: | Salary paid in lieu of comp? | Death result of injury?

Employer: Send copies to Insurer (or Workers' Compensation Division if no insurer), employee, and employee's union (if applicable)

GENERAL INSTRUCTIONS TO THE EMPLOYER

Employers, not employees, are responsible for completing this form. The information is needed to determine liability and entitlement to benefits. You must file this form with your insurer, and give a copy to the employee and the employee's local union office. You are required to provide the employee with a copy of the Employee Information Sheet, which is available on the Department of Labor and Industry's web site at www.dli.mn.gov.

Filing this form is not an admission of liability. You must report a claim to your insurer whenever anyone believes that a work-related injury or illness that requires medical care or where lost time from work has occurred. If the claimed injury wholly or partially incapacitates the employee for more than **three** calendar days, the claim must be made on this form and reported to your insurer within **ten** days. Your insurer may require you to file it sooner. Failure to file within the **ten** days may result in penalties. It is important to file this form quickly to allow your insurer time to investigate the claim. **Your insurer will report the injury** to the Department of Labor and Industry (Department), when necessary. Self-insured employers have 14 days to report the injury to the Department, when necessary.

If the claim involves death or serious injury (including injuries that later result in death), you must notify the Department and your insurer within 48 hours of the occurrence. The claim can be reported initially to the Department by telephone (651-284-5041), fax (651-284-5731), or personal notice. The initial notice must be followed by the filing of this form with the Department within **seven** days of the occurrence, at P.O. Box 64221, St. Paul, MN 55164-0221.

SEND THIS FORM TO YOUR INSURER IMMEDIATELY – DO NOT WAIT FOR THE DOCTOR'S REPORT

SPECIFIC INSTRUCTIONS TO THE EMPLOYER ON COMPLETING THIS FORM

- Item 2: OSHA case #. Fill in the case number from the OSHA 300 log. This form contains all items required by the OSHA form 301.
- Items 17-21: Fill in all the wage information. If the employee does not work a regularly scheduled work week, attach a 26 week wage statement so your insurer can calculate the appropriate average weekly wage. Attach a separate sheet giving the weekly value of any meals, lodging, or 2nd income paid to the employee.
- Item 20: Fill in the average number of days per week that the employee works. Also include their normal work schedule, Sunday - Saturday, by checking the appropriate boxes. If the employee's work schedule fluctuates from week-to-week, leave the boxes blank.
- Items 22-24: Be as specific as possible in describing: the events causing the injury; the nature of the injury (cut, sprain, burn, etc.), and the part(s) of body injured (back, arm, etc.); and the tools, equipment, machines, objects or substances involved.
- Item 26: Fill in the first day the employee lost any time from work (including time lost for medical treatment), even if you paid the employee for the lost time.
- Item 27: Check the appropriate box to indicate if there was lost time on the date of injury and whether you paid for that lost time.
- Item 28: Fill in the date you first became aware of the injury or illness.
- Item 29: Fill in the date you became aware that the lost time indicated in Item 26 was related to the claimed injury.
- Item 30: Leave the box blank if the employee has not returned to work by the time you file this form. If the employee has returned to work, fill in the date and answer the questions in Items 31 and 32. Notify your insurer if the employee misses time due to this injury after that date.
- Item 34: Check all the boxes that apply AT the time you file this form.
- Item 39: Fill in your Federal Employer Identification Number (FEIN). For information, see https://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Lost-or-Misplaced-Your-EIN.
- Items 40 and 44: Fill in your Unemployment ID number and North American Industry Classification System (NAICS) code, which are both assigned by the Minnesota Unemployment Insurance Program (651-296-6141).
- Items 46-54: Your insurer or claims administrator will complete this information if you do not have it available.

INSTRUCTIONS TO THE INSURER/CLAIMS ADMINISTRATOR
(For first reports of injury filed on or after Jan. 1, 2014)

Pursuant to Minnesota Statutes, section 176.231, and Minnesota Rules, part 5220.2530, insurers and self-insured employers must file with the Department's Workers' Compensation Division an electronic first report of injury, according to the requirements set out in sections 2 to 4 of the Minnesota implementation guide, in all cases where a first report of injury is required to be filed under Minnesota Statutes, chapter 176. The Minnesota implementation guide can be found on the Department's website at www.dli.mn.gov/WC/Edi.asp.

A first report of injury submitted by the insurer or self-insured employer in any other manner or format is not considered filed with the division, except for a written first report of injury on a paper form filed by a self-insured employer within seven days of death or serious injury.

If the claim does not involve lost time beyond the waiting period or potential permanent partial disability (PPD), or has not been requested to be filed by the Department, a first report of injury does **not** need to be filed.

This material can be made available in different forms, such as large print, Braille or audio. To request, call (651) 284-5032 or 1-800-342-5354 Voice or TDD (651) 297-4198

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

RENVILLE COUNTY ACCIDENT/INCIDENT INVESTIGATION REPORT
INSTRUCTIONS

Accident/Incident Investigations Are Required
Under Minnesota AWAIR (A Workplace Accident and Injury Reduction) Program standards, organizations are required to investigate workplace accidents to determine causes, take corrective actions, and prevent future accidents. The depth and quality of these investigations varies greatly depending on the circumstances of the organization and severity of the accident.

The Accident/Investigation Report seeks to improve the quality of accident/incident investigations by prompting supervisors, department heads, and others to ask applicable questions and determine the root cause(s) of the incident. The report also seeks to provide information when filing a workers' compensation claim and provide claim representatives with necessary information to process claims more efficiently.

If an employee is injured or if injury could result from the incident (a bee sting or tick bite, for example)the first half of this report can be used to populate the first report of injury (FROI) when submitting the report to Samantha Best (who coordinates with HR and MCIT) in a timely manner. Please submit this information as soon after the injury as possible. The remainder of the report can then be used to further the accident investigation.

If the employee is not injured and the incident is considered a near miss, use this report starting at the "Where did the incident occur?" question. Answering that and the following questions helps provide information to discover the underlying causes of the incident and aid in developing corrective action to mitigate similar incidents in the future.

When gathering information, always remember that the goal of the investigation is to determine what happened to prevent it from happening again; *it is not to find fault or blame.*

The Report Form
Nonpublic Employee Data (shaded box)
Most of the information within the shaded area is required when filing a workers' compensation claim. This specific information can also be considered non-public data and care should be given to who sees this information.

If a safety committee or other nonauthorized person reviews information from this form, the *data in the shaded area should be redacted before sharing.* Although it is necessary for processing the claim, it is not necessary for reviewing the incident and determining cause(s).

Description of Injury
Be as specific as possible when filling out this section. The more accurate the information that can be provided to the workers' compensation representative, the better the claim can be processed and the injured individual given informed care.

When asking questions about the accident, pay attention to the mechanics of the injury: What was the body doing leading up to the moment of injury? Could there be other possible sites of injury other than the obvious?

Where did the injury occur?
Detail the precise location of the injury. Examination of the area may also uncover potential contributing causes to the incident.

How did the incident occur?
The incident should be broken down in sequential detail. It is important to gather this information as soon as possible because memories fade and details may be lost.

What conditions or actions contributed to the incident?
Check all of the applicable boxes. When investigating, consider the environment. Did noise, weather, poor housekeeping, unguarded machinery, misused or unused personal protective equipment, inappropriate shoes, or other conditions contribute to the incident? Was the employee rushed, taking a shortcut, not paying attention, not adequately trained, or act in a manner that contributed to the incident?

What preventive measures were taken to prevent incidents?
List measures that are in-place to prevent incidents from occurring (use of hand rails; wearing appropriate footwear for the job, job-site, or season; using a three-point grip, etc.).

Who are the witnesses to the incident?
Were there others nearby and what did they see? Witnesses should be interviewed as soon as possible to get their description of the incident.

Have similar incidents like this occurred in the past?
This may take more time to research, but it is important to know if similar incidents have previously occurred and if measures were put in place to try to reduce them.

What is the root cause(s) of the incident?
With the information gathered from the previous questions, analysis can begin. Are there underlying factors that contributed to the incident beyond what was discovered? Unless the root cause(s) can be found, the potential for a future similar incident remains. There are a number of ways to try to determine root cause, but one of the easiest is called the "five whys."

To demonstrate this technique, consider an accident where a highway employee is burned adding a block of tar to a tar pot:

1. Ask "why did the employee get burned?" Hot tar splashed up onto his hands.
2. "Why did the hot tar splash up onto his hands?" He wasn't wearing protective gloves.
3. "Why wasn't he wearing protective gloves?" They are uncomfortable and are difficult to wear.
4. "Why are they uncomfortable?" They are the only ones available and come in only one size.
5. Further questioning might discover that the employee didn't feel comfortable going to his supervisor about finding a better fitting glove or that he wasn't aware of other gloves available. Both could be addressed by better communication and training.

Given the root cause(s), what can be done to prevent a recurrence of this type of incident?
After identifying the root case(s), the supervisor should then make a plan of how to prevent future injuries from occurring. This plan should include steps and give clear responsibilities of who would be responsible for completing the corrective actions. This process may also include the department head or other employees and their feedback.

Rest of the form, records retention
The remainder of the report form helps to track the corrective action plan and ensure follow up.

The Safety Committee reviews incidents, not reports, and provides feedback.

With proper consideration being given to the non-public data, this form is retained to show the accident/incident investigation process meets the requirements set forth in the AWAIR Program.

Contact Samantha Best, Safety Coordinator for More Information

For more information concerning accident/incident investigations, contact Samantha Best at (320)523-3839 or samb@renvillecountymn.com. Samantha is the Safety Coordinator for the County and the Secretary of the Safety Committee.

RENVILLE COUNTY ACCIDENT/INCIDENT INVESTIGATION REPORT

(To be completed immediately after incident, even where there is no injury)

Information collected in gray box may be nonpublic data and should only be shared with those whose job reasonably requires access to it.

Name of Injured Employee ______________________________ Unit ______________

Dept. ______________ Job Title ______________ Years of Service ____ Time on Present Job ______________

Does injured employee have other employment? ☐ YES ☐ NO If YES, where? ______________________

Contact person at other employer: ______________________ Telephone Number: ______________________

Hours/Week: ______________________________ Hourly Wage: ______________________

Date/Time Injury Reported and to Whom ______________________ Date Received Medical Treatment ________

Severity of Injury: (check appropriate box and give brief explanation)

☐ First Aid Only ____

☐ Doctor's Care ____

☐ Lost Time: ☐ Yes ☐ No First Day of Lost Time ______________________

Has Employee Returned to Work? ☐ Yes ☐ No Date ______________________

☐ Near Miss ____

Date Injured ____________ Hour ________ A.M. P.M. Time Started Work That Day ______________________

Description of Injury (Be as specific as possible)

- Type of Accident (fall, etc.): ______________________________
- Type of Injury (sprain, etc.): ______________________________
- Body Parts Affected: ______________________________

Where did the incident occur? ______________________________

How did the incident occur (to be completed by supervisor and employee)? ______________________________

____

What conditions or actions contributed to the incident? (select all applicable)

☐ Noise ☐ Lighting ☐ Vibration ☐ Damaged/Unstable Surface

☐ Layout/Design ☐ Dust/Fume ☐ Slip/Trip Hazard ☐ Equipment Failure

☐ Inadequate Maintenance ☐ Inadequate Guarding ☐ Inadequate Training ☐ Wrong equipment for job

☐ Material/Equipment Too Heavy/Awkward ☐ Hazard Not Identified ☐ Hazard Not Reported

☐ No/Inadequate Risk Assessment Conducted ☐ No/Inadequate Safe Work Procedure

☐ No/Inadequate Controls Implemented ☐ Inadequate Training/Supervision

☐ Procedure Not Followed/No Procedure Exists ☐ Drugs/Alcohol ☐ Fatigue

☐ Time/Production Pressures ☐ Change of Routine ☐ Lack of Communication

☐ Distraction/Personal Issues/Stress

☐ Other (describe) ____

What preventive measures were taken to prevent incidents (hand rails, appropriate footwear, three-point grip, etc.)?

____

Who are the witnesses to the incident? ____

Were photographs taken? If so, where are they located? ______________________________

Have similar incidents like this occurred in the past? ☐ YES ☐ NO
If YES, what corrective action was taken at that time?______________________________

____

What is the root cause of the incident? ______________________________

____

Given the root cause(s), what can be done to prevent a recurrence of this type of incident? (List action plan in step sequence)

____

Who will take this action? ______________________________

Date Prepared: ______________ ______________________________
Signature of Supervisor

DEPARTMENT HEAD'S RECOMMENDATIONS
How will you ensure that the plan of action to prevent or control recurrences is implemented? ______________

____

Recommendation(s): ______________________________

Date: ______________ ______________________________
Signature of Department Head

DATE OF SAFETY COMMITTEE'S REVIEW ______________________________

SAFETY COMMITTEE REVIEW
Is review and follow-up analysis on corrective action required? ☐ YES ☐ NO
Comments: ______________________________
If yes, outcome ______________________________

If work order or repairs needed, date completed: ______________________________
Comments: ______________________________

INJURY PREVENTION RECOMMENDATIONS
The Safety Committee has discussed this incident and has determined the recommendation below to help avoid a reoccurrence of that type of injury in the future: ______________________________

Please complete this section as to changes/new policies or procedures that have been put in place to prevent a reoccurrence. ______________________________

PERSONNEL OR SAFETY COORDINATOR REVIEW
Comments: ______________________________

Date:______________ ______________________________
Signature of Personnel/Safety Coordinator