EMPLOYEE'S REPORT OF INCIDENT AND INJURY
PLEASE PRINT IN INK To be completed by Employee

Employer: **Policy No:**
Location of Inury/Incident: _____

Name_____ Social Sec. No._____
Home Address_____ Birth Date_____ Sex: ☐ Male ☐ Female
City/State/Zip_____ Telephone: ( )_____

Date of injury **or** onset of symptoms_____ Time_____ ☐ am ☐ pm
Described what caused the injury/symptoms, what you were doing **just before** the incident, and what you did **after** the incident (if you need more space, write on the back of this form). **Be specific - name any objects or substances involved:**_____
_____
_____
_____

Did anyone see you get hurt? ☐ Yes ☐ No If yes, who?_____
Did you report this incident to anyone? ☐ Yes ☐ No If not, why not?_____
If yes, to whom did you report it?_____ Title/Position_____ When?_____

What part(s) of your body was/were affected? (BE SPECIFIC: for example, right elbow, left knee, right index finger):
_____
_____
What type of injury did you experience? (BE SPECIFIC: for example, bruise, scrape, laceration, pull)_____
_____

Was any first aid provided at the scene? ☐ Yes ☐ No If yes, describe:_____
_____
Did you seek other medical treatment? ☐ Yes ☐ No If yes, when?_____
Where?_____ If treatment was not sought immediately, explain why: _____
_____

Is this an aggravation of a previous injury/symptom? ☐ Yes ☐ No If yes, when were you last treated for the previous injury? _____ By whom or where?_____
Have you ever had a similar injury? ☐ Yes ☐ No If yes, describe other injury:_____
_____

Medical Release

Under current workers' compensation law, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)_____

Employee Signature_____ Date (required)_____

SUPERVISOR'S INVESTIGATION REPORT

Employer:
Employee Name:_____ **Soc. Sec. #**_____
Date of Injury:_____

Was an investigation completed concerning the circumstances of this injury? ☐ Yes ☐ No

Were there any witnesses to this injury? ☐ Yes ☐ No
If yes, witness statements should be attached.

Was the injury a result of horseplay? Under the influence of drugs, or purposely self-inflicted? If yes, please specify: ☐ Yes ☐ No

_____
_____
_____

Has there been any recent disciplinary action taken against this employee? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Has the employee missed any work previously due to similar industrial or non -industrial conditions? If so, when? ☐ Yes ☐ No _____

Has the employee submitted medical documentation for the injury? ☐ Yes ☐ No
If so, please attach.

If known, please provide us with the name, address and telephone number of the attending physician:

_____
_____
_____
_____

Has the employee returned to work? ☐ Yes ☐ No
Last day worked_____ Returned to work_____

If not, what is the current estimated date of return?_____

With the information you have, would you recommend the claim be accepted? ☐ Yes ☐ No
If no, why?_____
_____

Employer's signature	Title	Date

PLEASE ATTACH COMPLETED INCIDENT REPORTS, WITNESS STATEMENTS AND ANY ACCUMULATED MEDICAL BILLS AND INFORMATION. ADDITIONAL COMMENTS MAY BE NOTED ON THE REVERSE SIDE.

STATEMENT OF WITNESS TO ACCIDENT

Employer:

I. INCIDENT IDENTIFICATION INFORMATION

Name of employee alleging incident_____ Shift_____

Occupation_____ Department_____

II. WITNESS STATEMENT

Your name has been given as a witness to an incident alleged by the above individual. Through your cooperation, information can be obtained to complete the investigation of this incident. Therefore, it will be appreciated if you will answer each of the following questions and promptly return your completed statement.

Your name_____ Your occupation_____

Your address_____ Your telephone number ( ) _____ - _____

_____

Did you see an accident involving the above employee? ☐ Yes ☐ No

If not, how did you learn about the accident?_____

_____

If you did see an accident occur: Date of accident_____ Time of accident_____ ☐am ☐pm

Describe what you saw: _____

_____

_____

_____

_____ _____ _____

Your signature Please print your name Date

State of Ohio ¶

County of _____ ¶

Before me, a Notary Public in and for said state, personally appeared the above named who acknowledged before me that he/she did sign the foregoing instrument and that the same is his/her free act and deed.

In testimony whereof, I have hereunto affixed my name and official seal at _____, Ohio this _____ day of _____, 19_____.

(SEAL)

(signed)_____

Name (printed or typed)_____

Notary Public, State of Ohio

My Commission Expires_____**(date)**

Ohio | Bureau of Workers' Compensation

Authorization to Release Medical Information

Instructions

*You can obtain this form online at **ohiobwc.com***

- Please print or type.
- List the provider(s) you are authorizing to release medical records in the space indicated on this form.
- Please sign and date the form, and send it to the customer service office where your claim is located or to your self-insured employer.

Injured worker name (first, M.I., last)		Date of injury		Claim number
Address	City		State	Nine-digit ZIP code
Employer name	Employer MCO or QHP			

I, the above-named injured worker, understand I am allowing the Ohio Rehabilitation Services Commission and the providers (persons or facilities) named here (_____

_____) that attend or examine me to release the following medical, psychological and/or psychiatric information (excluding psychotherapy notes) that are related causally or historically to physical or mental injuries relevant to my workers' compensation claim:

- Pathology slides and immunohistochemical staining results, if applicable;
- Hospital admission history and physical; emergency room reports; hospital discharge summaries; physician office notes; physical therapist, occupational therapist or athletic trainer assessments and progress notes; consultation reports; lab results; medical reports; surgical reports; diagnostic reports; procedure reports; nursing home and skilled nursing facilities documentation; home nursing progress notes; or other listed below.

_____.

I understand I am authorizing the release of this information to the following: the Ohio Bureau of Workers' Compensation (BWC), the Industrial Commission of Ohio, the above-named employer, the employer's managed care organization or qualified health plan and any authorized representatives.

I understand this information is being released to the above-referenced persons and/or entities for use in administering my workers' compensation claim.

This authorization to release medical, psychological and/or psychiatric information shall remain in effect for as long as my workers' compensation claim remains open under Ohio law. I understand I have the right to revoke this authorization at any time. However, I must submit my revocation in writing and file it with BWC or my self-insured employer. My decision to revoke this authorization will be effective, except in the case that any provider referenced above already has relied on my authorization and released information.

I understand the provider(s) referenced above may not make my completing and signing this authorization a condition of my treatment.

I understand the parties I am authorizing the release of information to are exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 as they administer workers' compensation programs. Information disclosed pursuant to this authorization may be redisclosed by them and may no longer be protected by the federal privacy requirements. I understand such redisclosures may include but are not limited to the following:

- A copy of the medical information the employer receives may be forwarded to BWC by the employer;
- A copy of the medical information will be available to me or my physician of record upon request to BWC or to the employer.

Injured worker (or guardian or personal representative) signature	Date

If signed by the injured worker's guardian or personal representative, provide a description of the guardian or personal representative's authority to sign on behalf of the injured worker. _____

_____.

Ohio | Bureau of Workers' Compensation

Physician's Report of Work Ability

Injured worker name	Claim number	Date of injury
Employer name and injured worker's position of employment at time of injury	Date of last exam or treatment	Next appointment date

Injured worker progress

1 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
If a MEDCO-14 was previously completed for this injured worker, are there any changes to the information provided in Section 2 through 7 to report at this time? ☐ Yes ☐ No *If yes, proceed to section 2. If no, proceed to section 8.*

Work status

2 Did you review a description of the injured worker's job duties as they existed on the date of injury (former position of employment)? Check all applicable boxes.

☐ Yes, I was provided a job description (verbal or written) by the ☐ Injured worker ☐ Employer ☐ MCO

☐ No, I have not been provided a job description.

Select one of the three options below.

☐ Injured worker is temporarily not released to any work, including the former position of employment from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 4, 5, 6, 7 and 8.*

☐ Injured worker is not released to the former position of employment but may return to available and appropriate work with restrictions, from (date): ____/_____/_____ to ____/_____/_____. *Please complete required sections 3, 4, 5, 6, 7 and 8.*

The restrictions are: ☐ Permanent ☐ Temporary If temporary until what date? ____/_____/_____

☐ Injured worker is released to the former position of employment without restrictions as of (date): ____/_____/_____.

Is this date the day the injured worker actually returned to work? ☐ Yes ☐ No ☐ I don't know: *Proceed to section 8 and complete it.*

Injured worker's capabilities: Employer will use information in this section to evaluate available and appropriate work opportunities

3

How many total hours is this injured worker potentially able to work? _____ Hours in a day _____ Hours in a week

Upper extremities

The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

Lower extremities

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both

Medications

The injured worker is able to safely perform work duties which, if applicable, may include operating heavy machinery or driving while taking prescribed medications: ☐ Yes ☐ No

If no, what are the potential side effects: ☐ Dizziness ☐ Drowsiness ☐ Impaired ability ☐ Other, please explain

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously

Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C	Activity	N	O	F	C	Activity	N	O	F	C
0 – 10 lbs.					13 to 25 lbs.					Bend					Reach above shoulder				
11 – 20 lbs.					26 to 40 lbs.					Squat					Type/keyboard				
21 – 40 lbs.					41 to 60 lbs.					Kneel					**Driving**				
41 – 60 lbs.					61 to 100 lbs.					Twist/turn					Automatic				
61 – 100 lbs.					100 + lbs.					Climb					Standard shift				

In an eight-hour workday, how many total hours is the injured worker potentially able to work?

Sit: ___ hours ☐ Continuously ☐ With break | **Walk:** ___ hours ☐ Continuously ☐ With break | **Stand:** ___ hours ☐ Continuously ☐ With break

Degree of functional impairment based on allowed psychological conditions only, if applicable.

	None	Mild	Moderate	Marked	Extreme
Activities of daily living: Self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, social and recreational activities and occupational functioning	☐	☐	☐	☐	☐
Social functioning: Capacity to interact and communicate effectively and get along with others	☐	☐	☐	☐	☐
Concentration, persistence and pace: Ability to sustain focused attention long enough to complete tasks commonly found in the workplace	☐	☐	☐	☐	☐
Adaptation: Ability to appropriately react to stressful circumstances, including the workplace; includes attendance, making decisions, scheduling or completing tasks and interacting with supervisors and co-workers	☐	☐	☐	☐	☐

Injured worker name	Claim number	Date of injury

Disability period information (all fields required, including site/location if applicable)

4 Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and ICD code for the conditions being treated due to the work-related injury. Please indicate if the condition is causing temporary total disability **(all fields required, including site/location, if applicable).**

Narrative description of the work-related condition	Site/Location If applicable	ICD code	Is the condition causing temporary total disability?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

List all other conditions being treated (attach additional sheet if necessary).

Clinical findings

5 Provide your clinical and objective findings supporting your medical opinion outlined on this form. List any barriers to return to work and any reason for the injured worker's delay in recovery.

Maximum medical improvement (MMI)

6 MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability in spite of continuing medical or rehabilitative procedures. An injured worker may need supportive treatment to maintain this level of function. Note: periodic medical treatment may still be requested and provided.

Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No

If yes, give MMI date: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Vocational rehabilitation

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions, and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? ☐ Yes ☐ No If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Treating physician's name (please print legibly)			Physician PEACH number	
Address	City	State	Nine-digit ZIP code	Telephone number – –
Treating physician signature			Date	Fax number – –

First Fill
Temporary Pharmacy Card

Making it easy to get your workers' compensation prescriptions filled.

Just follow these easy steps…

Employer:

Print this page immediately upon receiving notice of injury, fill in the information below and give it to your employee.

Injured Employee:

1. If you need a prescription filled for a work-related injury or illness, go to a Tmesys network pharmacy.
2. Give this page to the pharmacist.
3. The pharmacist will fill your prescription at no cost.

tmesys®

Prescription Card

CARRIER/TPA	EMPLOYER/OTHER ENTITY
Sedgwick	Kenyon College

INJURED WORKER NAME

SOCIAL SECURITY NUMBER | DATE OF INJURY

Please provide directly to Pharmacist

Notice to Cardholder: This card should be presented to your pharmacy to receive medication for your work-related injury. It is only valid within 30 days of your date of injury. For information regarding the program or to find nearby pharmacies call **866.599.5426**.

Attention Pharmacists: Call **800.964.2531** to establish First Fill benefit eligibility and obtain the ID# for online adjudication of approved benefits for the injured worker.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy
Help Desk 800.964.2531

	NDC		Envoy
RxBin	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

(To create a card for your wallet, cut along outer line and fold in half.)

Pharmacist:

1. Call the Tmesys Pharmacy Help Desk at **800.964.2531.**
2. Provide the information listed above.
3. The Help Desk will provide an ID number for adjudication.

Finding a Network Pharmacy

Use one of these easy methods to find a network pharmacy:

- Visit one of the following pharmacy chains:

Walgreens	**Walmart**	**Foster's Eastside Pharmacy**	**Foster's Pharmacy**
Rite Aid	**CVS**		

- Use our pharmacy locator online: **www.pmsionline.com/pharmacy-center**.
- Call us: **866.599.5426**

tmesys®

Tmesys Retail Pharmacy Network*

More than 60,000 pharmacies, including large chains and many neighborhood independent pharmacies, meaning that your prescription can be filled at most pharmacies nationwide.

Accredo Health Group
Anchor Pharmacy
Arrow Prescription Center
Aurora Pharmacy
Baker's Pharmacy
Bartell Drugs
Bashas' United Drug
Bel Air Pharmacy
Big Y Pharmacy
Biggs Pharmacy
Bi-Lo
Bi-Mart
Bioscrip Pharmacy
BJ's Pharmacy
Brookshire's Pharmacy
Bruno's Pharmacy
Buehler's Pharmacy
Caremark Pharmacy
Carle Rx Express
Carrs Quality Center
City Market Pharmacy
Clinic Pharmacy
Coborn's/Cash Wise
Concord Drugs
Costco Pharmacy
Cub Pharmacy
CVS Pharmacy
D&W Pharmacy
Dahl's Pharmacy
Dierbergs
Dillon Pharmacy
Discount Drug Mart
Doc's Drug
Dominick's Finer Foods
Drug Emporium
Drug Mart
Drug Town
Drug Warehouse
Drugs For Less
E. W. James Pharmacy
Eagle Pharmacy
Eaton Apothecary
Econofoods Pharmacy
Edwards Pharmacy
Fagen Pharmacy
Family Drug Store
Family Fare Pharmacy
Family Pharmacy
Familymeds Pharmacy
Farm Fresh Pharmacy
Farmer Jack Pharmacy
Food 4 Less Pharmacy
Food City Pharmacy
Food Lion Pharmacy
Food Town Pharmacy
Food World Pharmacy
Foster's Eastside Pharmacy
Foster's Pharmacy
Fred Meyer Pharmacy
Fred's Pharmacy
Fruth Pharmacy
Fry's Pharmacy
Gemmel Pharmacy
Gentiva Health Services
Genuardi's Pharmacy
Gerbes Pharmacy
Giant Eagle Pharmacy
Giant Pharmacy
Glen's Pharmacy
Good Day Pharmacy
Grand Union Pharmacy
Gristedes Pharmacy
H-E-B Pharmacy
Haggen Foods
Hannaford
Happy Harry's
Harmons Pharmacy
Harps Pharmacy
Harris Teeter
Hartig Drug
Harvest Foods Pharmacy
Harveys Supermarket Pharmacy
Hen House Pharmacy
Hi-School Pharmacy
Homeland Pharmacy
Hometown Pharmacy
Hy-Vee Pharmacy
Ingles Pharmacy
Kmart Pharmacy
Kerr Drug
King Kullen Pharmacy
King Soopers Pharmacy
Kings Pharmacy
Kinney Drugs
Klingensmith's
Knight Drugs
Kohl's Pharmacy
Kohll's Pharmacy
Kopp Drug
Kroger Pharmacy
Lewis Pharmacy
Lifechek Drug
Longs Drug
Louis and Clark
Lowes Marketplace
Marc's Pharmacy
Marsh Drugs
Martin's Pharmacy
May's Drug Store
Med-Fast Pharmacy
Medical Arts Pharmacy
Medicap Pharmacy
Medicine Shoppe Pharmacy (various)
Med-X Drug
Meijer Pharmacy
Minyard Pharmacy
Morton Pharmacy
Mr. Discount Drugs
Navarro Discount Pharmacies
NeighborCare Pharmacy
No Frills Pharmacy
Network Pharmacy
Owens Pharmacy
P&C Food & Pharmacy
Pamida Pharmacy
Park Nicollet Pharmacy
Pathmark Pharmacy
Pavilions Pharmacy
PharmaCare Pharmacy
Pharmacy Express
Pharmacy Plus
Pick 'N Save Pharmacy
Piggly Wiggly
PrairieStone Pharmacy
Price Chopper Pharmacy
Price Cutter Pharmacy
Publix Pharmacy
Q Pharmacy
QFC Pharmacy
Quality Markets Pharmacy
QuickChek Pharmacy
QVL Pharmacy
Rainbow Pharmacy
Raley's Drug Center
Ralphs Pharmacy
Randalls Pharmacy
Reasors Pharmacy
Rite Aid Pharmacy
Ritzman Natural Health
Rosauers Pharmacy
RXD Pharmacy
Sack 'n Save Pharmacy
Safeway Pharmacy
Sam's Pharmacy
Save Mart Pharmacy
Save-Rite Pharmacy
Schnucks Pharmacy
Scolaris Pharmacy
Sedanos Pharmacy & Discount
Shaw's Pharmacy
Shaws/Osco Pharmacy
Shop 'n Save Pharmacy
Shopko Pharmacy
Shoppers Pharmacy
ShopRite Pharmacy
Snyder Drug Emporium
Southern Family Market
Star Pharmacy
Stop & Shop Pharmacy
Sunscript Pharmacy
Super 1 Pharmacy
Super D
Super G
Super Foodmart Pharmacy
Super Fresh Pharmacy
Super Rx Pharmacy
Sweetbay
The Pharm
Thriftway Drugs
Thrifty White Drug
Times Pharmacy
Tom Thumb Pharmacy
Tops Pharmacy
U-Save Pharmacy
Ukrops Pharmacy
United Pharmacy
USA Drug
Vix Pharmacy
Vons Pharmacy
VG's Pharmacy
Waldbaum's Pharmacy
Walgreens
Wal-Mart Pharmacy
Wegman Pharmacy
Weis Pharmacy
White Drug
Winn-Dixie
Yokes Pharmacy

*List subject to change. This is a partial listing only.

SELF INSUREDS

WHAT TO DO IF YOU ARE INJURED ON THE JOB

sedgwick

If you become injured or sick on the job, we want to help you get well and get back to work.

A work-related injury or illness can upset your life. Suddenly, you may find your health, your work and your enjoyment of leisure activities threatened. You may be confused about how and where to get the attention you need to get back on your feet. You may be concerned about the hassles and red tape you have to go through.

Relax. To help you through this difficult time, your employer has formed a team to assist you in your recovery. The team includes:

- Your employer's workers' compensation representative – a person you can turn to for advice on how to get started.
- Sedgwick – known for its understanding of work-related injuries and illnesses and its rapid response to injured employees' needs.
- An experienced provider network –physicians, therapists, and other health professionals specially qualified to treat your work-related injury or illnesses.

Sedgwick is ready to help you, the most important member of the team, get well so you can get back to work. We'll stand by you throughout the entire workers' compensation process, helping make sure you have access to the quality care you deserve.

When you become sick or injured on the job, Sedgwick is ready to assist you in getting the care you need.

Follow these five steps to help ensure you get the treatment and benefits due you.

1. Report the Injury Immediately

Unless it's a life-threatening emergency, report your injury, accident, or illness to your supervisor or company representative before you leave work. Failure to report an injury may cause delay in getting benefits due to you.

2. Get your ID Card and Forms

This packet contains your ID card and necessary forms, which include an Incident Form, First Report of Injury and a Medical Release. Complete the forms with your supervisor or company representative. He or she will need these in order to report your injury. Take your ID card to the medical provider. Be sure to use the ID card each time you visit your medical provider.

3. Seek Medical Treatment

Your supervisor or company representative will help you select a medical treatment site. Your visit to the provider should take place as soon as possible after your injury. When you go for your first visit, take your ID card (included in this packet). Remember to take your ID card to all subsequent visits with the provider.

4.Let Your Employer Know

After each appointment, let your company representative know you've seen your medical provider. In addition, Sedgwick will assist to manage your care, help arrange your return to work, and keep your employer updated on your condition.

5. Evaluate your Treatment Provider

We hope you will be pleased with the provider you choose. However, if for any reason you wish to see a different provider or treatment facility, contact Sedgwick. We will do our best to work with you to find a new provider or treatment center.

QUESTIONS ABOUT WORKERS' COMPENSATION

What does Workers' Compensation cover?

Injured employees receive benefits for work-related injuries and work-related illnesses.

Benefits may include the following medical expenses:

- routine physician visits
- medications
- diagnostic tests
- eyeglasses and dentures
- hospitalization
- artificial limbs
- surgery
- rehabilitation services

You may receive wage benefits if the job-related injury causes you to lose time from work. If a work-related injury or illness should prove fatal, workers' compensation pays death benefits to your survivors. This plan overview is intended to be a brief outline of procedures and coverage and is not intended to be a legal contract. If you have questions regarding death benefits, please contact your company's workers' compensation coordinator.

Helping yourself get better, faster

There are several steps you can take when recovering from a work-related injury that will help your return to work:

- Be involved in your treatment. Talk about what you expect with your provider. Ask questions. If you don't understand something, say so.
- Stay informed about your progress. Know what forms are needed. Know where and when to deliver the completed forms.
- Keep records by making copies of letters, payment stubs, etc.
- You have a right to copies of your medical records, however, you might be charged by your provider for these copies.
- You have the primary responsibility in the return-to-work process. Sedgwick, your company workers' compensation representative, your provider and other treatment specialists are all members of the recovery team. But you are the most important member.

Alternative work duty

If, during your recovery period, you are not yet ready to return to your old job, Sedgwick will work with you and your employer to help ensure a safe, productive return in a modified-duty position tailored to suit your condition until you regain full capacity.

Employee rights and responsibilities

You have the primary responsibility in the return-to-work process. Sedgwick, your company's workers' compensation coordinator, your provider and other treatment specialists are all members of the recovery team. But your are the more important member.

You must report the work-related injury or illness to your supervisor as soon as possible after the incident.

Your supervisor will assit you to identify a treatment site location where you will go to receive initial treatment for your work-related injury or illness. He or she will also provide you with a Sedgwick ID card and an informational brochure. You must present the Sedgwick ID card each time you visit any medical provider who is providing treatment for your work-related injury or illness.

You should inform the provider that you experienced the injury or illness while on the job. If you experience a life-threatening injury on the job, you should always receive the necessary emergeny medical treatment from appropri ate providers whether or not they are part of the network.

If you have questions or concerns about your medical care or return to work, please utilize the following contact information:
Customer Service: 800-267-4001, fax 614-210-2663 or mail to Sedgwick, PO Box 14521 Lexington KY 40521.

sedgwick

Workers' Compensation Identification Card
(800) 825-6755 Phone
(614) 658-0901 Fax
This person's Employer is self-insured.
Policy # 20005746-0

sedgwick

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(614) 658-0901 Fax
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Policy # 20005746-0

FAX all information within 24 hours of visit to Sedgwick at (614) 658-0901. Employer requires release from physician at the time of your return to work.

Send bills to:
Sedgwick
PO Box 14661
Lexington, KY 40512

Sedgwick for Kenyon College
Attn: Kase Van Buskirk
Phone: (614) 658-0950
Fax: (614) 658-0901

Sedgwick provides administrative services and Network access only and does not assume any financial risk or obligation with respect to claims. This card does not guarantee claim approval.

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Lexington, KY 40512

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Fax: (614) 658-0901

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