Ozark Action, Inc.

Work Comp Safety Compliance Steps to Report Work Place Injuries

Safety First

"Equal Opportunity Employer"

Updated: 7/1/2017
TO: Employees/Supervisors/Directors  
FROM: Sheryl Roberts, Corporate Services Director  
RE: Workers' Compensation—Report of Work Related Injuries

Please be aware that all injuries must be reported immediately by the employee to the immediate supervisor. Ozark Action, Inc. (OAI) must give prior approval in order for anyone to receive treatment for a work comp related injury. If it is a life or death situation, the worksite will assist the employee and call OAI with the injury report as soon as the employee is receiving life or death assistance.

Once the accident has been reported to the supervisor; the supervisor should call Ozark Action, Inc. at 417-256-6147 and speak with Ruthie Lee, Kelsey Tooley or Sheryl Roberts for immediate assistance during Monday through Friday 8:00 a.m. to 4:30 p.m. After hours, please call Sheryl Roberts at 417-257-9525—this is a cell phone and should not be called unless absolutely necessary.

When medical care is not necessary, please contact Ruthie, Kelsey or Sheryl and fax the employee incident statement; authorization to obtain information; work comp authorization for medical treatment; supervisor incident/injury report; incident witness statement; and incident corrective action form to 417-256-0333.

When medical care is necessary, please contact Ruthie, Kelsey or Sheryl. Please have information such as the employee’s name, date of birth, social security number, time of accident, body part injured and where the accident occurred ready to give to Ruthie, Kelsey or Sheryl over the phone. At this point Ozark Action, Inc. will contact a medical provider to schedule an appointment or advise the supervisor if it is a life or death situation where to send the employee. If it is non-life threatening, OAI representative will then make arrangements for a medical provider and will call the immediate supervisor with instructions on where the employee is going to and how to get to the physician’s location. Prior to the employee leaving for the appointment, the employer needs to complete the back side of the return to work form. The employer will complete the employer’s physical capacities requirement form. The employee will need to take the return to work/physical capability form with them to the physician at the time of their appointment. The doctor will complete this form, give it back to the employee and the employee must give it to the immediate supervisor.

While the central office will be making the appointment arrangements, the employee must complete the employee incident statement. The supervisor and any witnesses will need to complete their sections as well. Once those items are complete, the employee incident report, as well as the authorization to obtain information; Work Comp authorization for Medical Treatment form; Supervisor Incident/Injury Report; Incident Witness Statement, and the Incident Corrective Action Form must be faxed immediately to Ozark Action, Inc. at 417-256-0333.

When the employee goes to their appointment, they need to take the return to work/physical capability form with them (employer should have completed the employer’s physical requirements side before employee leaves for the appointment).

When the employee returns from the appointment, the supervisor should get the return to work/physical capability form and any other supporting documentation that was given to the employee and fax all of this information to OAI at 417-256-0333.

I, the undersigned employee, have read and understand that if I do not report an injury immediately to my supervisor and Ozark Action, Inc.; and If I seek treatment without prior approval from OAI that I would be liable for any charges for treatment. By signing below I acknowledge that I have read and understand if I do not follow these procedures as described above that OAI will not be held liable or responsible for any injuries or treatment that was not pre authorized in advance.
Complete this form and fax it to 417-256-0333

All claims should be reported to Ozark Action, Inc. within 24 hours.

TO: Ozark Action, Inc.

FROM: Name of injured employee: _______________________

Date injury reported to employer: _______________________

417-256-6147.

Ozark Action, Inc.
Attn: Corporate Services Department
710 E. Main St.
West Plains, MO 65775

FAX: 417-256-0333; Phone: 417-256-6147
Email: sroberts@oaiwp.org; rlee@oaiwp.org; or ktooley@oaiwp.org

43-0838508
Injury Reporting Kit

Steps to follow in the event of a workplace injury.

☐ ASSESS THE SITUATION.
If emergency medical attention is needed, CALL 911 IMMEDIATELY!

☐ If not an emergency, have employee sign the
AUTHORIZATION TO OBTAIN INFORMATION and
fax to 417.500.0333

☐ Complete the WORK COMP AUTHORIZATION FOR
MEDICAL TREATMENT and place in Injured Employee Kit.

☐ Submit the WORK COMP DECLINATION OF MEDICAL
TREATMENT if the injured employee denies treatment.

☐ Complete EMPLOYER'S PHYSICAL CAPACITIES
REQUIREMENTS and place in Injured Employee Kit.

☐ Immediately review INJURED EMPLOYEE KIT
with injured employee. Be sure to include details regarding
the upcoming medical appointment and instruct them to take the
Injured Employee Kit with contents to the medical appointment.

☐ DIRECT INJURED EMPLOYEE TO:

Clinic: ____________________________
Location: __________________________
Phone: ____________________________

☐ REPORT INJURY TO MEM WITHIN 24 HOURS.
You can report the injury to MEM directly by:
- logging on to www.mem-ins.com
- calling 1.800.442.0593
- faxing it to 1.800.442.0597

For more information or additional kits:

- www.mem-ins.com
- 1.800.442.0593
- claims@mem-ins.com

Contents
Authorization to Obtain Information
Work Comp Authorization for Medical Treatment
Work Comp Declination of Medical Treatment
Return to Work/Physical Capability Form
Report of Injury Fax Cover Sheet
Report of Injury Form
Incident Investigation Report
Incident Witness Statement
Incident Corrective Action Form
Injured Employee Kit

Next Steps
☐ Complete and mail INCIDENT INVESTIGATION REPORT including gathering witness statements.

☐ Complete and mail INCIDENT CORRECTIVE ACTION FORM.

☐ If you haven’t already, mail AUTHORIZATION TO OBTAIN INFORMATION to MEM.

☐ Maintain contact with injured employee by making regular calls or visits.

☐ Plan the injured employee’s return to work, whether it be full or transitional duty.
AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any licensed physician, medical practitioner, nurse, pharmacist, hospital, clinic or other medical or medically related facility, insurance or reinsurance company, consumer reporting agency, employer or former employer who has any information as to the diagnosis, treatment or prognosis of any physical or mental condition of me, and any information regarding my occupation and salary, to give any and all such information to Missouri Employers Mutual Insurance, its employees, reinsurers, any designated Managed Care Organization, and the Division of Workers' Compensation to which I am submitting a claim.

I UNDERSTAND that the information obtained by use of this authorization will be used by the company to determine eligibility for workers compensation benefits. Any information obtained will not be released to any person or organization except to other persons or organizations performing a business or legal service in connection with my claim or as may be otherwise permitted or required by law. The release of my Protected Health Information to a person or organization not subject to federal law governing privacy, which then rediscloses my Protected Health Information, may mean that the protections afforded by the federal privacy laws no longer apply.

I UNDERSTAND the information contained in these records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and drug or alcohol use or abuse. I HEREBY CONSENT AND AUTHORIZE the medical record provider to release and provide records containing this information to Missouri Employers Mutual Insurance.

I AUTHORIZE MEM to discuss my health information with my authorized treating physician, evaluating physician and/or medical care provider and with my Employer and their representatives and agents for the purpose of managing and adjudicating my workers compensation case(s).

I KNOW that I may request to receive a copy of this authorization.

I AGREE that a photocopy of this authorization shall be as valid as the original.

I AGREE that this authorization shall be valid for the duration of this claim, unless I choose to withdraw this authorization in writing.

Date ______________________ Print Name of Injured Employee ______________________

Signature of Injured Employee or Authorized Representative

*NOTE TO RECORD PROVIDER:
The Health Insurance Portability and Accountability Act (HIPAA) expressly indicates that a patient's consent or authorization is not required for records to be disclosed when the request is made pursuant to workers compensation laws. See 45 CFR Section 164.512(f). This request for records is made pursuant to The Missouri Workers' Compensation Act, Section 287.210 RSMo, subsections 5 and 6.

Submit completed form to:

Ozark Action, Inc.
710 E. Main Street
West Plains, MO 65775-3307
417-258-6147
www.oalwp.org

Revised Feb. 2013
# Employee Incident / Injury Report

**Name of Injured Employee**

**Date of Incident**

**Time of Incident**  □ A.M.  □ P.M.

**Date Reported**

**Department**

**Job Performed**

**Manager**

**Employer**

**MEM Policy No.**

**Employer Contact Name**

**Employer Telephone Number**

**Incident Location**

**Extent of Injury**

- □ No Injury  □ First Aid Only  □ Taken to Clinic  □ Taken to ER  □ Fatality

**Treating Medical Facility**

**Body Part Injured**

**Description of Incident**

**Any Other Witnesses?**  □ Yes  □ No

**Name and Phone No.**

**Name and Phone No.**

**Name and Phone No.**

**Were There Others Injured?**  □ Yes  □ No

**Name and Phone No.**

**Name and Phone No.**

**Name and Phone No.**

**Report Completed by**

**Signature**

**Date**

**Title**

**Phone Number**

Submit completed form to:

**Osler Action, Inc.**

**Attica Corporate Services Department**

**718 E. Main St.**

**West Plains, MO 65775**

**FAX:** 417-256-0333; **Phone:** 417-256-0147

E-mail: robferd@oslerinc.com; jfried@oslerinc.com; or accpersona@oslerinc.com

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*Please complete the diagram on reverse side.*
Indicate Pain Level Below

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>SLIGHT</td>
<td>MODERATE</td>
<td>SEVERE</td>
<td>UNBEARABLE</td>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE:** ___________________________ **DATE:** __________

**WITNESS:** ___________________________ **TITLE:** __________ **DATE:** __________
WORK COMP AUTHORIZATION FOR MEDICAL TREATMENT

EMPLOYER INFORMATION

Employer: ________________________________

Treatment Authorized by: ________________________________

Title: ________________________________

Telephone Number: ________________________________

INJURED EMPLOYEE INFORMATION

Employee: ________________________________ Social Security Number: ________________________________

Job Title: ________________________________

Department: ________________________________ Location(s): ________________________________

Date of Injury: ________________________________ Body Part Injured: ________________________________

Work Comp Insurance Carrier: Missouri Employers Mutual Insurance:

TREATMENT AUTHORIZATION

Please check all that apply:

☐ Initial Evaluation and Treatment

☐ Alcohol Screening

☐ Drug Screening

Note to employers: You must have a Drug and Alcohol Policy in place that complies with Missouri law prior to selecting drug and alcohol screening.

☐ Return-to-Work Exam

☐ Per Telephone Instructions

☐ Other

REMARKS:

Submit a copy of this completed form to:

Ozark Action, Inc.
710 E. Main Street
West Plains, MO 65775-3307
417-296-6147
www.ozwpi.org

Place this completed form in the Injured Employee Kit to go to the treating physician.

Revised Feb. 2013
**WORK COMP DECLINATION OF MEDICAL TREATMENT**

**EMPLOYER INFORMATION**

Employer: ____________________________  
Treatment Authorized by: ________________  
Title: ____________________________  
Telephone Number: __________________

**INJURED EMPLOYEE INFORMATION**

Employee: ____________________________  Social Security Number: ________________  
Job Title: ____________________________  
Department: ____________________________  Location: ____________________________  
Date of Injury: ____________________________  Body Part Injured: __________________

*Work Comp Insurance Carrier: Missouri Employers Mutual Insurance.*

**TREATMENT DECLINATION**

I am **declining** my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on ________________ [insert date]. I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense.*

I also understand that if I reconsider and am interested in receiving authorized medical care, I must advise my employer as soon as possible.

Employee Signature ____________________________  Date ________________

* If the employee desires, they shall have the right to select their own physician, surgeon, or other such requirement at their own expense. Section 287.140.1

**REMARKS**

Submit completed form to:

**Ozark Action, Inc.**
710 E. Main Street
West Plains, MO 65775-3307
- 417-266-6147
- www.oaiwp.org

Revised Feb. 2013
# Employer's Physical Capacities Requirements

**Employee name**

**Policyholder name**

**Policy No.**

**Department**

**Job title**

**Hours per shift**

**Date of injury**

## Basic job requirements

<table>
<thead>
<tr>
<th>Activity</th>
<th>Continuously 67-100%</th>
<th>Frequently 34-66%</th>
<th>Occasionally 11-33%</th>
<th>Seldom 1-10%</th>
<th>Restricted 0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mobility**

- Lifting
- Bending
- Squatting
- Reaching
- Kneeling
- Pushing
- Pulling

## Other physical requirements

This side to be completed by employer. Opposite side to be completed by physician.
Return to Work/Physical Capability Form

Patient ____________________________  Physician ____________________________

Diagnosis

Treatment (needed for OSHA rules and placement):
☐ Narcotic analgesic  ☐ Anti-inflammatory medication  ☐ Sutures
☐ Physical therapy  ☐ Other ____________________________

I saw this patient on (date) ____________ and based on the above description of the patient’s current medical problem (check all that apply):

☐ Return to regular duty on (date) ____________
☐ Return to work on (date) ____________ with restrictions:
  ☐ temporary  ☐ permanent
☐ Off-work until (date) ____________

Patient to be reevaluated: ____________ days ____________ weeks.

☐ Heavy work. Lifting 50 lbs. frequently with occasional lifting and/or carrying objects weighing up to 100 lbs.

☐ Medium-heavy work. Lifting 40 lbs. frequently with occasional lifting and/or carrying objects weighing up to 75 lbs.

☐ Medium work. Lifting 25 lbs. frequently with occasional lifting and/or carrying objects weighing up to 50 lbs.

☐ Light-medium work. Lifting 20 lbs. frequently with occasional lifting and/or carrying objects weighing up to 30 lbs.

☐ Light work. Lifting 10 lbs. frequently with occasional lifting and/or carrying objects weighing up to 20 lbs. Even though the weight lifted may be a negligible amount, this category would include any job that requires walking or standing to a significant degree or involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ Sedentary work. Lifting 15 lbs. maximum and occasionally lifting and/or carrying such articles as files, light packages and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

Condition:  ☐ Improved  ☐ Symptoms Worse  ☐ Unchanged  ☐ Not Applicable

Total hours of work per day:
☐ 4 hours  ☐ 6 hours  ☐ 8 hours  ☐ 10 hours  ☐ No restriction  ☐ Other ____________

Continuous 67-100%  Frequently 34-66%  Occasionally 11-33%  Seldom 1-10%  Restricted 0%

Hand: Specify—Right [R]; Left [L]; Bilateral [B]

☐ Not applicable
Sit/drive ☐ ☐ ☐ ☐
Stand ☐ ☐ ☐ ☐
Walk ☐ ☐ ☐ ☐
Bend ☐ ☐ ☐ ☐
Twist ☐ ☐ ☐ ☐
Climb ☐ ☐ ☐ ☐
Squat ☐ ☐ ☐ ☐
Work overhead ☐ ☐ ☐ ☐
Work shoulder level ☐ ☐ ☐ ☐

Feet: Specify—Right [R]; Left [L]; Bilateral [B]

☐ Not applicable
Grasp ☐ ☐ ☐ ☐
Pincer grip ☐ ☐ ☐ ☐
Reach ☐ ☐ ☐ ☐
Twist (wrist) ☐ ☐ ☐ ☐
Push/pull w/hands ☐ ☐ ☐ ☐
Wrist flexion/extension ☐ ☐ ☐ ☐

Repetitive movements as in operating foot controls ☐ ☐ ☐ ☐

☐ No exposure to moving machinery  ☐ No exposure to unprotected heights
☐ Avoid wet work  ☐ Avoid irritants (specify)

Patient referred to (physician) ____________________________________________

Other instructions and/or limitations ____________________________________________

__________________________________________ Date ____________ Time ____________

Physician signature ____________________________

This side to be completed by physician. Opposite side to be completed by employer. Date: ____________________________
Missouri Employers Mutual has made it possible for you to obtain necessary medicine(s) for work-related injuries with no out-of-pocket expense.

<table>
<thead>
<tr>
<th>Simply provide the pharmacist with the following information:</th>
<th>Instructions for pharmacist on reverse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My employer is: ___________________________</td>
<td>2. My insurance carrier is Missouri Employers Mutual.</td>
</tr>
<tr>
<td>3. This is a workers compensation claim.</td>
<td>4. My date of injury is: ____________</td>
</tr>
<tr>
<td>5. My birthdate is: ___________________________</td>
<td>6. My SSN is: ________________________</td>
</tr>
</tbody>
</table>

Please note that this coupon is for injured employees to retrieve only their first fill prescription resulting from a workplace injury. It is authorized for the injured employee only and is non-transferable.
Dear Pharmacist:

Missouri Employers Mutual works with pharmacies throughout the state to make it possible for injured employees to obtain necessary medicine(s) without incurring out-of-pocket expenses.

The program guarantees that you will be paid for this first fill if you:
- Provide the injured employee the first fill (10 days) prescription only.
- Confirm the patient has notified their employer so an MEM pharmacy card can be issued for subsequent prescriptions.

For future prescriptions:
- If the injured employee does not present an MEM pharmacy card, confirm eligibility by calling MEM at 1.800.442.0593.
- Consult with treating physicians to address perceived inadequacies or excesses of care.

BIN No: 004336    RX PCN: ADV    RX Group No: RXFFWC225

For claim processing assistance, please call CorVel Pharmacy Solutions at 1.800.563.8438.
Complete this form and fax it to
Attn: HR — 417-256-0333

All claims should be reported to MEM within 24 hours.

To: Missouri Employers Mutual Insurance
   Attention: Customer Service Center

From: Name of company: Ozark Action Inc.

Name of injured employee: __________________________

Date injury was reported to employer: ________________

Please indicate what type of injury you are reporting.

☐ This is a "report only" claim. Our employee is not expected to lose more than three days of work and we will be paying all, if any, bills to the extent permitted under Missouri Workers' Compensation Law. If you have questions about when a claim is report only, please call 1.800.442.0593.

☐ This is a "medical only" claim. We don't expect this employee to lose more than three days of work. Please pay any necessary bills associated with this claim.

☐ This is a "lost time" claim. Our employee will lose more than three days of work. Please pay any necessary bills associated with this claim.

Do you have any concerns about the validity of this claim?

☐ yes    ☐ no

If yes, a Claims Representative will contact you as soon as possible.

Revision Date — April 2017
# MEM Report of Injury Form

## General

- **Employer (Name & Address Inc. Zip)**
- **Carrier/Administrator Claim Number**
- **Jurisdiction**
- **Jurisdiction Claim Number**
- **Report Purpose Code**
- **Insured Report Number**
- **Employer's Location Address (If Different)**
- **Location**
- **Phone**

## Carrier/Claims Admin

- **Carrier (Name, Address & Phone No)**
- **Missouri Employers Mutual**
- **101 N. Kerne Street**
- **Columbia, MO 65201**
- **1.800.442.0593**

## Carrier FEIN

- **Policy/Self-Insured Number**

## Administrator FEIN

- **Agent Name and Code Number**

## Carrier/Claims Admin

- **Date of Birth**
- **Sex**
- **Marital Status**
- **Occupation/Job Title**
- **Employment Status (i.e., Full Time, Part-Time, etc.)**
- **NCCI Class Code**

## Name (Last, First, Middle)

- **Date of Injury/Illness**
- **Time of Occurrence**
- **Date Employer Notified**
- **Date Disability**

## Wage

- **Rate**
- **Per**
- **Day**
- **Month**
- **Other**
- **No. of Days Worked/Week**
- **Full Pay for Day of Injury?**
- **Yes**
- **No**

## Occupation

- **Date Hired**
- **State of Hire**

## Employee

- **Address (Inc. Zip)**
- **Sex**
- **Marital Status**
- **Employment Status (i.e., Full Time, Part-Time, etc.)**
- **NCCI Class Code**

## Date of Injury/Illness

- **Date of Injury/Illness**
- **Time of Occurrence**
- **Last Work Date**

## Contact Name/Phone Number

- **Department or Location Where Accident or Illness Exposure Occurred**
- **All Equipment, Materials, or Chemicals Employee was Using When Accident or Illness Exposure Occurred**
- **Specific Activity the Employee was Engaged in When the Accident or Illness Exposure Occurred**
- **Work Process the Employee was Engaged in When Accident or Illness Exposure Occurred**

## Occurrence

- **How Injury or Illness/Anomalous Health Condition Occurred. Describe the Sequence of Events and Include Any Objects or Substances that Directly Injured the Employee or Made the Employee Ill.**

## Date to Return to Work

- **If Fatal, Give Date of Death**
- **Were Safeguards or Safety Equipment Provided?**
- **Yes**
- **No**

## Treatment

- **Physician/Health Care Provider (Name & Address)**
- **Hospital (Name & Address)**
- **Initial Treatment**
  - **No Medical Treatment**
  - **Minor by Employee**
  - **Minor: Clinic/Hospital**
  - **Emergency Care**
  - **Hospitalized Greater Than 24 Hrs**
  - **Future Major Medical/Lost Time Anticipated**

## Others

- **Witness (Name & Phone #)**
- **Date Administrator Notified**
- **Date Prepared**
- **Preparer's Name & Title**
- **Phone Number**

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The shaded portions will be completed by Missouri Employers Mutual. White areas to be completed by policyholder.

ROI Form—Revised Jan. 2013
# Incident Investigation Report

**THIS IS NOT A REPORT OF INJURY FORM. PLEASE REPORT THE INJURY ONLINE AT WWW.MEM-INS.COM OR BY CALLING 1.800.442.0593.**

**THIS REPORT TO BE COMPLETED BY EMPLOYER.**

<table>
<thead>
<tr>
<th>Name of Injured Employee</th>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Date Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ A.M. □ P.M.</td>
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<td>Hire Date</td>
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<table>
<thead>
<tr>
<th>Job Title/Department</th>
<th>MEM Policy No.</th>
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<table>
<thead>
<tr>
<th>Employer</th>
<th>Employer Contact Name</th>
<th>Employer Telephone No.</th>
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<tr>
<th>Job Performed</th>
<th>Experience Performing Job</th>
</tr>
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<table>
<thead>
<tr>
<th>Location of Incident</th>
<th>Person Incident was Reported To</th>
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<table>
<thead>
<tr>
<th>Extent of Injury</th>
<th>Treating Medical Facility</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>□ No Injury</th>
<th>□ First Aid Only</th>
<th>□ Taken to Clinic</th>
<th>□ Taken to ER</th>
<th>□ Fatality</th>
</tr>
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</table>

| Description of Incident | |
|--------------------------||
|                         | |

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<thead>
<tr>
<th>Any Witnesses?</th>
<th>□ Yes □ No</th>
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<table>
<thead>
<tr>
<th>Name and Phone No.</th>
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</thead>
<tbody>
<tr>
<td>Any Witnesses?</td>
<td>□ Yes □ No</td>
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<table>
<thead>
<tr>
<th>Were there others injured?</th>
<th>□ Yes □ No</th>
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<tr>
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<td>□ Yes □ No</td>
<td></td>
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| Was there physical damage? | |
|----------------------------||
|                            | |

| Cause of Incident | |
|-------------------||
|                   | |

## Contributing Incident Factors

**Physical**

- □ Poor Housekeeping
- □ Poor or no equipment guarding
- □ Improper illumination
- □ Improper ventilation
- □ Equipment failure
- □ Unsafe Apparel
- □ Medical condition, e.g. Stroke, Cardiac arrest
- □ Surrounding subcontractor at fault
- □ Conditions e.g. wet
- □ Other
- □ Other

**Behavioral**

- □ Not using required PPE
- □ Performing duties outside of scope of job
- □ Failure to obey supervisor's instructions
- □ Failure to obey job procedures
- □ Suspected intoxication
- □ Employee was engaged in horseplay
- □ Employee was unsuited for the job
- □ Other
- □ Other
- □ Other
- □ Other

**Procedural**

- □ Asked to perform job without training
- □ Operating equipment without training
- □ Poor enforcement of PPE use
- □ Needed equipment not supplied
- □ Failure to inspect equipment
- □ Failure to correct poor procedures
- □ Wearing equipment for the operation
- □ Wrong chemical or other used
- □ No pre-site inspection
- □ Other
- □ Other

<table>
<thead>
<tr>
<th>Report Completed by</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Title/Employer</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Submit completed form to: Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205
Fax: 1.800.442.0597
Email: claims@mem-ins.com

**Revised Feb. 2013**
**INCIDENT WITNESS STATEMENT**

This is not a report of injury form. Please report the injury online at www.mem-ins.com or by calling 1.800.442.0593.

<table>
<thead>
<tr>
<th>Name of Witness</th>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Date Reported</th>
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<tbody>
<tr>
<td>Department</td>
<td>Job title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer (If not an employee)</td>
<td>Phone number (If not an employee)</td>
<td></td>
<td>Hire Date</td>
</tr>
<tr>
<td>Location of Incident</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Name of Injured Employee | | |

<table>
<thead>
<tr>
<th>Name of Injured Employee's Employer/MEA Policy No.</th>
<th>Employer's Phone Number</th>
</tr>
</thead>
</table>

**Description of Incident**


**Physical Conditions at the Time of Incident**


**Any other witnesses?**

- Yes
- No

<table>
<thead>
<tr>
<th>Name and Phone No.</th>
<th>Name and Phone No.</th>
<th>Name and Phone No.</th>
</tr>
</thead>
</table>

**Were there others injured?**

- Yes
- No

<table>
<thead>
<tr>
<th>Name and Phone No.</th>
<th>Name and Phone No.</th>
<th>Name and Phone No.</th>
</tr>
</thead>
</table>

**Report Completed by**

<table>
<thead>
<tr>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
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<tbody>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Submit completed form to:

Missouri Employers Mutual Insurance
P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597

Email: claims@mem-ins.com
**INCIDENT CORRECTIVE ACTION FORM**

THIS IS NOT A REPORT OF INJURY FORM, PLEASE REPORT THE INJURY ONLINE AT WWW.MEM-INS.COM OR BY CALLING 1.800.442.0593.

<table>
<thead>
<tr>
<th>Employee Name or Incident Reference</th>
<th>Date of Incident</th>
<th>Time of Incident</th>
<th>Date Reported</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer</th>
<th>MEM Policy No.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Contact Name</th>
<th>Employer Telephone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Location of Incident</th>
</tr>
</thead>
</table>

**Brief Description of Incident**

**Do you know of any similar incidents occurring in the past?**

- ☐ Yes
- ☐ No

If yes, please describe incidents.

---

**Corrective Action**

---

**Date Corrective Action Completed**

**Corrective Action Performed By**

**Corrective Action Reference Number (e.g. work order, P.O. or account number)**

**Follow Up Action Required**

---

**Follow Up Action To Be Completed By**

**Report Completed by**

**Signature**

**Title**

**Date**

---

Submit completed form to: Missouri Employers Mutual Insurance

P.O. Box 1810, Columbia, MO 65205

Fax: 1.800.442.0597

Email: claims@mem-ins.com

REVISED FEB. 2013