

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/Administrator CLAIM NUMBER		OSHA LOG CASE #		REPORT PURPOSE CODE			
		JURISDICTION		JURISDICTION CLAIM NUMBER					
		INSURED REPORT NUMBER							
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
INDUSTRY CODE		EMPLOYER FEIN						PHONE #	
CARRIER/CLAIMS ADMINISTRATOR									
CARRIER (NAME, ADDRESS, & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)				
			TO						
			CHECK IF APPROPRIATE						
			<input type="checkbox"/> SELF INSURANCE						
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN				
EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE		
			<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS		
PHONE			# OF DEPENDENTS				NCCI CLASS CODE		
RATE PER:		<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE			
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					
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL								CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
				WERE THEY USED?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT		
							0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED		
OTHER									
WITNESSES (NAME & PHONE #)									
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE				PHONE NUMBER		

AWCC Form 1
(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversies including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.
2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.
3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.
4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

Form AR-S	ARKANSAS WORKERS' COMPENSATION COMMISSION	S
	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	
Authority: Ark. Code Ann. § 11-9-529 Revised: 1-1-2001		

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)		Employee SS Number	
Employer Name		FEIN No.	City	State	Zip Code
Carrier Or Self-Insured Name		NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

3. Has employee returned to work? Yes No If yes, give date _____

4. If employee has returned to work, is he/she earning the same wages as before the injury? Yes No

 If not, please explain:

5. Has employee died? Yes No If yes, give date of death: _____

ADDITIONAL INFORMATION

CERTIFICATION

I certify that the information above is accurate according to the employer's/carrier's records.			
Signature	Printed or Typewritten Name	Title	Date

AWCC Form S
(Supplemental Report)

This form reports any change-in-status, including, but not limited to:

1. The injured employee is back at work and drawing wages;
2. The injured employee is losing time again;
3. The injured employee has died;

Employers need to file **Form S** promptly.

Carriers file the form to fill in any "gaps" in time on **AWCC Form 4** when the case is being closed.

Contact the AWCC Office Services Section for help with the Form S. General information is available from the Support Services Division (1-800-622-4472 or 501-682-3930) .

Ark. Code Ann. §11-9-106(a):“Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers’ compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers’ Compensation Commission.”

Form AR- 2	ARKANSAS WORKERS' COMPENSATION COMMISSION 324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	2
Authority: Ark. Code Ann. §11-9-803, -810 Revised 1-1-2001		

EMPLOYER'S INTENT TO ACCEPT OR CONTROVERT CLAIM

Initial Filing **Amended Filing**

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)	Employee SS Number
Employer Name			Fed. Employer I.D. No.
Address		City	State Zip Code
Carrier or Self-Insured Name		NAIC No.	Claims Office Address

COMPENSATION (if not applicable, skip to next section)

Date of Injury	City, State of Injury	Dates Covered by First Check	Body Part Injured	First Date Indemnity Triggered (Disability Date)
Date of First Comp. Check	Average Weekly Wage	Weekly Comp. Rate	Check Condition if Applicable: <input type="checkbox"/> TPD <input type="checkbox"/> Medical - Only Claim (no indemnity due) <input type="checkbox"/> PTD <input type="checkbox"/> PPD-Only Case <input type="checkbox"/> Death	

CONTROVERSION SECTION

Date of injury or death: _____ Reason for controverting claim: _____

DEATH CASE DATA

List all Dependents below: *(If more space is needed, attach supplemental sheet)* If no Dependents, check here:

Attach Death Certificate of Deceased Employee and Birth Certificates for Dependent Children

Name of dependent	Date of birth	Relationship to deceased	Weekly benefit amount

CERTIFICATION

I certify that the foregoing is a complete and accurate report according to the records of the insurer pertaining to first payment, controversion and beneficiary information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

Signature	Printed or Typewritten Name	Title	Telephone No. Date

If insurer is represented by an attorney, that legal representative must sign below pursuant to Ark. Code Ann. § 11-9-717

Name and Address of Attorney	Signature

AWCC Form 2
(Employer's Intent to Accept or Controvert Claim)

A form used to accept a case and report payment or to controvert. **AWCC Form 2** also is used to amend positions taken earlier.

Help With AWCC Form 2:

1. The first payment to the employee is due by the 15th day after the employer has notice of the injury or death. **(Ark. Code Ann. §11-9-802)**
2. The AWCC is notified "upon making the first payment." **(Ark. Code Ann. §11-9-810)**
3. A controversion notice is due on or before the 15th day after notice of the death or alleged injury. **(Ark. Code Ann. §11-9-803)**
4. Therefore, **AWCC Form 2** in all cases is required by the 15th day from (a) the day of disability or (b) the day the employer is aware of the alleged incident, whichever date is later.

Be sure to include on **AWCC Form 2**:

5. A mark in either the Initial Filing Box or Amended Filing Box.
6. The AWCC File Number (obtained from **AWCC Form A-110**) and your company's file number for this case.


Be sure to bear in mind:

7. **Form 2** is NOT interchangeable with the required written response to the 15-day letter for **Form C**.
8. If respondents need additional time for investigation, an extension request must be sent in before the **Form 2** deadline. Using **Form 2** to report that the respondent needs more time is invalid. If anything is written in the Controversion Section ("we are investigating"), the AWCC will consider the case controverted.
9. If a case is opened at the AWCC on **Form 1** or **Form C**, an **AWCC Form 2** is required, even if the case upon investigation is determined to be a medical-only claim.

Questions about a specific Form 2 may be answered by the AWCC Office Services Division, which processes this form. General information may be obtained from the AWCC Support Services Division. (1-800-622-4472 or 501-682-3930)

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Ark. Code Ann. §11-9-717: (Summary) Any person or attorney signing a claim, request for benefits, controversion of benefits request for hearing or other paper of a party, certifies the action is taken after reasonable inquiry; is well grounded in fact; is warranted by existing law or a good faith argument for extension, modification or reversal of existing law; and is not interposed for any improper purpose or for delay. Violators of this provision may be subject to sanctions, which may include payment of reasonable expenses incurred by others and reasonable attorney fees for responding to the claim, request or motion, or for failure to appear at a hearing, deposition or other scheduled matter.

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	
	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001		

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City	State	Zip Code	

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name		
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident
What part of your body was injured? _____			
Briefly discuss the cause of injury: _____			

WITNESSES


Name and address of witness(es), if any: _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

<p>Form AR-N</p>	<p>ARKANSAS WORKERS' COMPENSATION COMMISSION</p> <p>324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472</p>	
<p>Ark. Code Ann. §§ 11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001</p>		

EMPLOYEE'S NOTICE OF INJURY

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately.

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:

(A) If the employer had knowledge of the injury or death;

(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or

(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.


CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e) . . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

- Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.
- You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.
- If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.
- If your employer has contracted with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.
- If your employer does not have a contract with a certified MCO**, you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Formulario AR-N Autoridad: Ark. Code Ann., apartado 11-9-702, 508, 514 AWCC Norma 33 Revisado: 1-1-2001 En Español: 10-15-2004 Actualizada: 8-1-2006	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS 324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	
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NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

DATOS DEL EMPLEADO (utilizar tinta y mayúsculas)

Apellido	Nombre	Fecha del 2º nombre	# de la Seguridad Soc.	Fecha de nacimiento	(Prefijo), número de teléfono particular
Dirección o apartado de correo		Ciudad		Estado	Código postal
<input type="checkbox"/> Tiene obligación de pagar manutención de sus hijos? <input type="checkbox"/> Estoy al corriente <input type="checkbox"/> Estoy atrasado/a <input type="checkbox"/> Pagaderos a:					

DATOS DEL EMPLEADOR (utilizar mayúsculas)

Nombre del empleador (denominación con la que opera)				(Prefijo), número de teléfono del empleador
Dirección del empleador		Ciudad del empleador		Estado
				Código postal

INFORMACIÓN SOBRE EL ACCIDENTE (utilizar mayúsculas)

Lugar del accidente	Fecha del accidente	Hora del accidente	Día	Hora
¿Qué parte del cuerpo se ha lesionado?			Empleador informado del accidente	
Describe brevemente las causas del accidente:				

TESTIGOS

Nombre y dirección de los testigos, si procede:

Por la presente autorizo a cualquier hospital, médico, psicoterapeuta o profesional sanitario a suministrar al portador cualquier dato, oral o escrito, incluidos, entre otros, copias de los registros médicos relativos a mi estado físico, mental o emocional pasado, presente o futuro. Por la presente renuncio a mi privilegio médico (y psicoterapeuta o profesional sanitario)-paciente. Una copia fotostática de la presente autorización será tan válida como y efectiva como el original. Mi firma a continuación también indica que se me ha ofrecido el ejercicio de mis derechos relativos al cambio de médico. (Véase la información adicional al dorso.)
 Fecha: _____ Firma: _____

Puede obtenerse ayuda con respecto al formulario N de la AWCC de la División del Asesor Legal (1-800-520-2511 o 501-682-3930). Puede obtenerse información de la División de Servicios de Soporte (1-800-622-4472 o 501-682-3930).

Ark. Code Ann., apartado 11-9-106(a): "Cualquier persona o entidad que realice consciente y voluntariamente una declaración o afirmación sustancial falsa o que omita u oculte consciente y voluntariamente un dato sustancial, o que utilice consciente y voluntariamente un dispositivo, sistema o artificio para: obtener una prestación o pago, engañar o aumentar o reducir ilegítimamente cualquier reclamación de prestaciones o pagos, u obtener o evitar la cobertura de compensación para los empleados o evitar el pago de la prima de seguro correspondiente, o que ayude e induzca a cualquiera de estos fines, será, en virtud del presente capítulo, culpable de un delito de Clase D. El cincuenta por ciento (50%) de cualquier multa penal impuesta y cobrada en virtud de... este artículo se pagará y adjudicará de acuerdo con la legislación aplicable al Fondo de Discapacidad Total Permanente y Faltamiento administrado por la Comisión de Compensaciones de los Trabajadores."

Formulario AR-N	COMISIÓN DE COMPENSACIÓN DE LOS TRABAJADORES DE ARKANSAS	N
Autoridad: Ark. Code Ann., apartado 11-9-702 Revisado: 1-1-2001 En Español: 10-15-2004	324 Spring Street, Little Rock, AR 72201 Correo: P.O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

NOTIFICACIÓN DE ACCIDENTE DEL EMPLEADO

NOTIFICACIÓN AL EMPLEADO - Cumplimente este formulario para entregarlo a su empleador inmediatamente.

Ark. Code Ann., apartado 11-9-701. Notificación de fallecimiento o lesión.
(a) (1) A menos que se trate de una lesión que impida mental o físicamente al empleado hacerlo, o si se comunica al empleador inmediatamente después de producirse, el empleado deberá informar del accidente a su empleador en una forma establecida o aprobada por la Comisión de Compensación de los trabajadores y a una persona y en un lugar especificado por el empleador, y el empleador no será responsable de las beneficias de discapacidad, médicas o de otro tipo anteriores a la recepción del informe del accidente.
(2) Todos los procedimientos de notificación que especifique el empleador deberán ser razonables y éste deberá notificar razonablemente a todos los empleados los requisitos de notificación.
(3) Lo anterior no será de aplicación si el empleado precisa tratamiento médico de urgencia fuera del horario de trabajo habitual del empleador; sin embargo, en ese caso, el empleado deberá hacer que se notifique el accidente al empleador el siguiente día laborable habitual.
(b) (1) La falta de notificación no anulará las reclamaciones si:
(A) El empleador tiene conocimiento del fallecimiento o lesión; o
(B) El empleado no tenía conocimiento de que la afección o enfermedad se produjo en el transcurso de su empleo; o
(C) La Comisión exime esta omisión basándose en que la notificación no pudo realizarse por un motivo justificado.
(2) Las objeciones relativas a la falta de notificación deberán plantearse antes o en el momento de celebrarse la primera vista de la reclamación.

ELECCIÓN/CAMBIO DE MÉDICO

Derechos y responsabilidades. El tratamiento o los servicios suministrados o prescritos por un médico distinto del seleccionado de acuerdo con las siguientes disposiciones, excepto el tratamiento de urgencia, correrán a cargo del solicitante/empleado.

Ark. Code Ann., apartado 11-9-508. Servicios y suministros médicos.

"(e) ...[E]l empleado lesionado podrá tener acceso directo a cualquier proveedor de servicios oftalmológicos u optométricos que acepte suministrar servicios de acuerdo con las normas y condiciones relativas a los servicios prestados por la entidad de atención gestionada inicialmente elegida por el empleador para el tratamiento y control de lesiones o afecciones de los ojos."

1. Su empleador podrá seleccionar al médico de atención primaria inicial de entre los asociados con MCOs certificadas.
2. Podrá solicitar un cambio de médico. Inicialmente debería solicitar un cambio a la aseguradora o el empleador. En el plazo de cinco días laborables desde su solicitud inicial de cambio de médico, la aseguradora o el empleador deberían notificarle su decisión de concederle o denegarle el cambio de médico.
3. Si su solicitud de cambio de médico es denegada podrá enviar una petición al Secretario de la Comisión de Compensación de los trabajadores para un (1) único cambio de médico.
4. Si su empleador tiene un contrato con una MCO certificada, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a la MCO certificada elegida por su empleador o que sea el médico que le atiende regularmente (Por "médico que le atiende regularmente" se entiende el facultativo que mantiene sus registros médicos y con el que cuente con un historial de tratamiento habitual anterior a la lesión para la que se puede solicitar la compensación"). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a la MCO certificada elegida por el empleador para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por la MCO certificada inicialmente elegida por su empleador.
5. Si su empleador no tiene un contrato con una MCO certificada, podrá cambiar de médico solicitando a la Comisión un (1) único cambio de médico por un facultativo que también deberá estar asociado a una MCO certificada o que sea el médico que le atiende regularmente (véase la definición anterior). El proveedor de atención sanitaria por el que cambie deberá aceptar remitirlo a una MCO certificada para cualquier tratamiento especializado, incluida la terapia física, y deberá aceptar cumplir todas las normas y condiciones relativas a los servicios prestados por cualquier MCO certificada.

Dorso/ formulario a dos caras



SUA[®]
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SUPERVISOR'S INCIDENT REPORT

Injury(work related)

Incident

Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr		Job Title			Department					
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time		End Time	
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____

2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Confusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments _____

Supervisor Signature _____

Date _____

SUA04 08/08



**WORKERS COMPENSATION
INJURY MEDICAL AUTHORIZATION**

**Authorization for Medical Records
And Communication Release**

By this form or copy thereof, I _____, hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other related medical or medically related facility, insurance company or other organization, institution, or person, that has any records or knowledge of my mental, physical health, history, condition or well being, to supply such information to my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer, it's insurer, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment and as to any other issues including but not limited to diagnosis, prognosis, causal connection of care and treatment to my work injury or duties and ability to work. In conjunction with this, I authorize any treating physician or medical provider to review any additional medical records provided to them.

I understand that by signing this authorization for medical records and communication release that my applicable medical provider will be releasing information subject to the HIPPA restrictions. I specifically waive any rights or protections that I may have under the HIPPA regulation and request that the medical providers release the requested information.

A photo copy of this authorization shall be valid as the original. This release shall remain valid for the length of my claim.

Name (Please Print)

Address (Street, City/Town, Zip Code)

Signature

Date Signed

SUA05 08/08



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ATTENDING PHYSICIANS RETURN TO WORK RECOMMENDATION RECORD

Claim No																											
Patients Name (First)	(Middle Initial)	(Last Name)	Date of Injury/Illness																								
TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK																											
Diagnosis/Condition (Brief Explanation)																											
I saw the and treated this patient on _____ and based on the above description of the patient's current medical problem:																											
1) <input type="checkbox"/> Recommend his/her return to work with no limitations on _____																											
2) <input type="checkbox"/> He/She may return to work on _____ capable of performing the degree of work checked below with the following restrictions:																											
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as docket, 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	1. In an 8 hour day patient may: a) Stand/Walk <input type="checkbox"/> None <input type="checkbox"/> 1-4 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 6-8 hours b) Sit <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours c) Drive <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 3-5 hours <input type="checkbox"/> 5-8 hours 2. Patient may use hand(s) for repetitive: <input type="checkbox"/> Single Grasping <input type="checkbox"/> Pushing & Pulling <input type="checkbox"/> Fine Manipulation 3. Patient may use foot/feet for repetitive movement as in operating foot controls <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div>																										
<input type="checkbox"/> 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 is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls	4. Patient is able to: <table style="width: 100%; border: none;"> <thead> <tr> <th></th> <th style="text-align: center;">Frequently</th> <th style="text-align: center;">Occasionally</th> <th style="text-align: center;">Not at All</th> </tr> </thead> <tbody> <tr> <td>Bend</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Squat</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Climb</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Twist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Reach</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Frequently	Occasionally	Not at All	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Frequently	Occasionally	Not at All																								
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
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Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
<input type="checkbox"/> Light Medium Work. Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.																											
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.																											
<input type="checkbox"/> Medium Heavy Work. Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds																											
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds																											
Other Instructions and/or Limitations Including Prescribed Medications:																											
The restrictions are in effect until _____ or until patient is reevaluated on _____																											
3) <input type="checkbox"/> He/She is total incapacitated at this time. Patient will be re-evaluated on _____																											
Physician's Signature			Date																								

SUA6 08/08



SUPERVISOR'S INCIDENT REPORT

 Injury (work related)

 Incident

 Illness (work related)

Employee Name (First, MI, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Home Telephone Number			
Employee's Street Address						City			State		Zip Code	
Age		Birth date Mo Day Yr		Job Title			Department					
Employee's Scheduled Work Week When Injured		Start time	End time	Hrs Per Day	Hrs Per Wk	Days Per Wk		Normal Full-Time Schedule for Injured's Work	Start Time	End Time		
Injury date Mo Day Yr		Hour of Day		Last Day Worked Mo Day Yr			Last Day Worked Mo Day Yr			<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No

If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will employee complete a drug screening? Yes No

Name of Witnesses Names (Attach statements if available)

1. _____

2. _____

Injured employee's statement of what happened. (Identify circumstances and equipment involved)

How could this incident been prevented?

What corrective action has been taken?

Part of Body Affected							
<input type="checkbox"/> Eye	<input type="checkbox"/> Hip	<input type="checkbox"/> Head	<input type="checkbox"/> Foot	<input type="checkbox"/> Neck	<input type="checkbox"/> Wrist	<input type="checkbox"/> Back	<input type="checkbox"/> Hand
<input type="checkbox"/> Arm	<input type="checkbox"/> Toes	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Ankle	<input type="checkbox"/> Fingers	<input type="checkbox"/> Elbow	<input type="checkbox"/> Leg	<input type="checkbox"/> Other
Type of Injury							
<input type="checkbox"/> Cut/Abrasion	<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Foreign Object	<input type="checkbox"/> Burn	<input type="checkbox"/> Break	<input type="checkbox"/> Sprain/Strain	<input type="checkbox"/> Exposure	
<input type="checkbox"/> Repetitive Motion	<input type="checkbox"/> Other						

Comments

Supervisor Signature _____

Date _____

SUA04 08/08



Hand Coordination Activities					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine manipulation					
Gross manipulation					
Simple grasping					
Power grip					
Hand twisting					
Pushing					
Pulling					
Tools Used by Worker		Weight	No. of Hands Needed to Move		
Objects Worker must Move During Day		Weight	Distance	No. of Workers Needed to Move	
Physical Surroundings			Does Employee Walk on Uneven Ground?		
Does Employee Work <input type="checkbox"/> Inside _____ % <input type="checkbox"/> Outside _____ %			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Drive Automotive Equipment?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe:					
Does the Employee Come in Contact with the Following? (indicated type)		Yes	No	Type	
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics of Job that cannot be Modified by Employer for this Employee					
Comments and/or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis			Title	Date	



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RETURN TO WORK LOG

Employee
Name _____

Supervisor

Date	Hours Worked		Tasks Performed	Comment Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I understand, take responsibility for and acknowledge the _____ has placed me on limitations my physician, Dr. _____ while Participating in this temporary transitional work program.

Employee
Signature _____

Date _____

SUA08 08/08



RETURN TO WORK LOG

The Return to Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps to eliminate potential conflicts should questions arise regarding your employees performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employees' restrictions to the log.
- Have employees write their name on top of the log and have the Supervisor write their name.
- Remind the employees it is their responsibility to follow the restrictions.
- Remind the employees the restrictions apply to occupational and non-occupational activities.
- Employees and Supervisors review all tasks completed each day and indicate any concerns. Initial after each day in confirmation of the review of tasks and consideration of concerns.
- Have the employees sign and date the Log at each week's end.



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ROLES & RESPONSIBILITIES

Employee:

If a work place accident should take place, it is your responsibility to take the following actions, injury permitting:

- You must report the injury to the employer on Form N and to a person or at a place specified by your employer, unless the injury either renders you physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs.
- For occupational diseases, you should notify your employer as soon as practicable after you become aware of the condition.
- You must go to the doctor chosen by your employer or your employer's workers' compensation insurance carrier.
- Be sure to do everything possible to cooperate with your employer and its workers' compensation carrier. If you do not, your benefits may be stopped or delayed. Be sure you:
 - Complete all workers' compensation forms in a timely manner.
 - Keep all appointments.
 - Report any earnings you get after your injury to the workers' compensation carrier.
 - Get approval from the carrier before receiving treatment. If you are not satisfied with the doctor first assigned, ask your claims handler or carrier to approve another doctor. You may also write to the Commission to request a Change of Physician.
 - Return to work as soon as the doctor says you can.
 - Be aware that your right to receive benefits and medical care may end if there has not been payment made or necessary medical care provided for a one year period.

Employer:

Upon notice of a work injury or occupational disease you should take the following steps:

- You must inform the insurance carrier or administrator responsible for the workers' compensation program via the agreed upon method, e.g. online reporting, facsimile, or telephonic reporting.
- To avoid delay of processing the claim it is recommended, at a minimum, the following information be provided to the insurance carrier or administrator:
 - Employee's name
 - Address
 - Telephone number
 - Social security number
 - Brief description of the injury, accident or disease
 - Authorization Release of Medical Information
 - Wage Earnings History
 - Notice of Claim Received
 - Witness statements and supervisor reports, if available.
- You must provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
- You or your insurance representative have the right to choose doctor(s) to treat injured employees, but notice of these choices must be given to employees.
- Comply with managed care requirements for contracted medical services, including but not limited to doctors, physical therapy locations, and diagnostic testing facilities when available.



Insurance carrier:

Once SUA receives notice of a work place injury via the agreed reporting method and the claim has been properly verified and set up, SUA will take the following steps:

- Three (3) point contact for all lost time claims, contact to the employer, employee and providers.
- SUA will report injuries on a First Report of Injury or Illness, Form IA-1 (rev. 1/1/02), as well as all other required reports to the Division of Workers' Compensation.
- SUA will ensure a timely determination of compensability by requesting from affected parties any information needed to determine:
 - a. If a temporary or permanent disability exists relative to the employee's ability to do their job.
 - b. If the disability is caused by the employee's work.