



Employee Injury or Illness Notification

The **employee** must complete the *Employee Injury or Illness Notification*. The employee's supervisor must then sign, date and return the form to the IMWCA Claims Department at 317 Sixth Avenue, Suite 800, Des Moines, IA 50309-4111. For questions on how to complete this form, contact IMWCA Claims Division at (515) 244-2708 or (800) 257-2708.

Employee Information (please print or type)

Name: _____ Social Security No: _____

Address: _____ City: _____

Zip Code: _____ Home Phone: () _____ - _____ Date of birth: ____/____/____

Sex: ____ Occupation: _____ Length of Employment: _____

Employer: _____

Accident Information

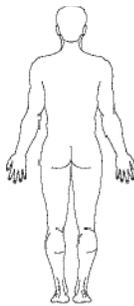
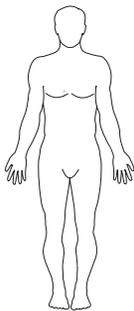
Date and time of injury: _____ Date and time injury reported: _____

How did the accident happen? (please describe in detail)

To whom did you report the accident? (list names)

Who was present when the accident occurred? (list names)

Indicate the injured part(s) of your body (specify right or left):



Have you ever injured this part of your body before? (circle one)

YES

NO

If yes, please describe:

Treatment Information

Does your employer require the use of a designated physician for workers' compensation injuries?
YES NO

If so, list doctor's name: _____

From whom did you first receive medical treatment? _____

Phone Number: () _____ - _____

Street address of facility: _____ City: _____

Street address of facility: _____ City: _____

Date of first treatment: _____ Are you still receiving treatment? YES NO
If yes, explain the type, frequency and length of anticipated treatment:

Return to Work

Did you miss more than three days of work? (circle one) YES NO
If no, skip the rest of the questions and sign the form.

On what date did you return to work? _____ If not working, when do you expect to return to work? _____

Has your physician placed restrictions on your activities? YES NO
If yes, explain:

Is there any job you can do with these restrictions? YES NO
If yes, what Job? _____

Did you discuss light duty with your supervisor? YES NO

The information in the box below must be completed if the employee missed more than three days of work.

| | |
|---|---|
| *This wage information and maximum exemptions are used to calculate workers' compensation rates for compensable claims. BE AS ACCURATE AS POSSIBLE. | |
| Marital Status: _____ | Are your earnings based on hourly wages? |
| Are you 65 or older? _____ | If so, \$ _____ x _____ = \$ _____ |
| Is your spouse 65 or older? _____ | (hourly rate) (no. of hrs) |
| Are you blind? _____ | If not based on hourly wages, show weekly earnings and how computed: _____ = \$ _____ |
| Is your spouse blind? _____ | |
| Number of dependent children: _____ | If gross wages vary, supply total earnings for last completed period of 13 weeks: _____ 13 weeks = \$ _____ |
| Other dependents? _____ | |
| Number of hours you normally work each week: _____ | |

Wage documentation must be attached to this report for all lost time claims.

Employee's Signature

(date signed)

Supervisor's Signature

(date signed)

AUTHORIZATION TO RELEASE INFORMATION

Name of Patient:

Date of birth:

I. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR REDISCLOSURE

I authorize _____ whose address is _____
_____ to disclose and deliver to

Iowa Municipalities Workers' Compensation Association, whose address is 317 Sixth Avenue, Des Moines, IA 50393-3688, the following information: **any and all medical records, including those predating the date of injury and initial patient questionnaire**

NOTE: *If information includes mental health treatment, substance abuse treatment or HIV-related information it will not be released unless you agree to the release on the reverse side of this form.*

I understand the information is being disclosed and may be used only for legal and/or litigation purposes relating to claims and/or suit against and/or arising out of incident(s) on or about _____

This authorization expires on, _____ (not to exceed one year); or, if no date is specified, on the termination of the litigation or other proceedings for which this authorization was provided.

I understand that I may refuse to sign this authorization or revoke this authorization at any time. I understand that my revocation or refusal to sign this authorization will not affect my ability to obtain health care services. I also understand that if I revoke, the revocation will take effect on the day it is received by the entity from whom disclosure is sought in writing.

I understand that if the person or entity that receives the information requested is not covered by the federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

Iowa and/or Federal law provides that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below. I further understand that the Recipient, WITHOUT FURTHER AUTHORIZATION, may redisclose said information to Parties and their legal counsel, insurers, experts, potential experts, anyone against whom claim is or has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any of said persons

I SPECIFICALLY AUTHORIZE AND CONSENT TO THE DISCLOSURE AND REDISCLOSURE DESCRIBED ABOVE.

X

Signature of Patient or patient's legal representative

Date

Name and relationship of patient's legal representative:

II. AUTHORIZATION FOR CONSULTATION

I understand that if the person or entity listed above is a physician, surgeon, physician's assistant, advanced registered nurse practitioner or mental health professional (provider) this authorization also permits to consult with that provider about my medical history and condition relating to my claims described above, and further permits that health professional to render opinions regarding the cause of my condition and the prognosis for that condition. I understand that if the lawyer seeking consultation represents a party adverse to me, that lawyer shall provide a written notice to my lawyer and other counsel consistent with the Iowa Rules of Civil Procedure for service of a notice of deposition at least ten (10) days prior to such consultation.

In order for the above consultation to be authorized, sign here and at the end of Section.

X

Signature of Patient or patient's legal representative

Date

Name and relationship of patient's legal representative: