

Policy Number: [1]

Policy Period: [2]

Workers Compensation Insurance Claims Kit

Our Workers Compensation Claim Kit and Workers Compensation Claims webpage will help you navigate the claims process. There are also mandatory postings required by the various state agencies. To access this information, visit societyinsurance.com, or scan this QR code with your mobile device.



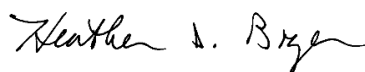
If an injury occurs at work:

- Address the immediate needs of the injured worker. If the injury requires immediate attention, call 911.
- For all non-emergent work injuries, the supervisor and injured worker should call the Society Nurse Triage hotline 24 hours a day, 7 days a week at (877) 501-3050 to speak to a nurse regarding the injuries and need for treatment, or to report a claim.

As always, your agent is an excellent resource should you have questions regarding the information in this package.

Please feel free to contact us at (888) 576-2438 if you have any additional questions regarding the claim process.

Sincerely,



President and CEO
Society Insurance

Employer's Claim Reporting Checklist

Important: This form is for the employer's use.

1. Address the immediate medical needs of your injured employee.
2. If any injury occurs that may be covered by your policy, let Society Insurance know as soon as possible. Please remember to contact us even when your injured employee will not require immediate medical treatment. Late reporting may result in fines.
3. Provide your injured employee with a copy of the Pharmacy Program Letter of Intent document. This letter is a temporary card that will allow your injured employee to receive an initial supply of medication. A permanent plastic card will be issued to them once the claim is setup.
4. Let us know if your injured employee's treatment will require any of the following:
 - An MRI, CT scan, or other diagnostic testing
 - Use of durable medical equipment (such as crutches or a knee brace)
 - Physical or occupational therapy
 - Chiropractic care
5. Have your injured employee's supervisor complete the Supervisor Incident Report. Be sure to secure the name, address, and phone numbers of any witnesses to the incident.
6. Set aside any materials or machinery that may have contributed to or caused the injury. Secure the name, address, and phone numbers of anyone you feel may be responsible for the injury. We may be able to seek recovery from a responsible party.
7. Provide your injured employee with a copy of the Attending Physician's Return to Work Recommendations Record. Please provide us with a completed copy of this form or any information you receive regarding return to work, or anticipated return-to-work dates. Please let us know if there will be no lost time involved with the claim.
8. Please let us know if you have any type of light-duty work available that you will be able to offer your injured worker when they are capable of returning to work.
9. Phone in your claim to a claim representative at 888-576-2438. If you know your policy number, please have it available when you call in. Please provide wage information on claims with lost time from work or those that have the potential for lost time. Do not delay your filing if the information is not readily available.
10. You may submit a First Report of Injury, along with any medical documentation that has been received, directly to Society Insurance at the address below. If you chose this method for submitting your claim, please keep a copy for your records.

Society Insurance
150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
Phone: 888-576-2438
Fax: 920-922-1071

Note: Always keep a supply of First Report of Injury forms on hand. You can obtain additional forms from our office. Please see the Claims Kit computer screen pull-outs for additional information regarding items contained on this checklist.

Injured Worker's Claim Reporting Checklist

Important: This form is for the injured worker's use.

1. If necessary, seek immediate medical attention for your injuries. Notify your employer if you feel your injuries were caused by your job duties, even if you do not plan on seeking immediate medical treatment.
2. Request a copy of the Pharmacy Program Letter of Intent from your employer. This letter will allow you to receive an initial supply of any medication that is needed for your injuries. A permanent plastic card will be issued to you once your claim is set up.
3. Let your claim representative know if your treatment has included or will likely include any of the following:
 - An MRI, CT scan, or other diagnostic testing
 - Use of durable medical equipment (such as crutches or a knee brace)
 - Physical or occupational therapy
 - Chiropractic care
4. Help your employer secure the names of any witnesses to your incident. Help your employer identify any materials or machinery that you feel may have contributed to or caused your injury.
5. Request a copy of the Attending Physician's Return to Work Recommendations Record from your employer. It is your responsibility to ensure that this document is completed by your physician and given to your employer immediately following every appointment.
6. Provide your employer with the names and addresses of any medical providers that have provided treatment for your injuries.
7. Request that your employer submit the First Report of Injury to us as soon as possible. We prefer to receive the information by phone or fax.
8. Your claim representative may contact you to obtain additional information that may be needed to complete the investigation of your claim. You may contact your claim representative at any time with questions regarding your claim:

Society Insurance
150 Camelot Drive
P.O. Box 1029
Fond du Lac, WI 54936-1029
Phone: 888-576-2438
Fax: 920-922-1071
9. Promptly complete and return any forms that you receive from your claim representative. These forms can be returned to us in the postage-paid envelope that you will receive with the forms.
10. Please contact your claim representative immediately following every appointment. This will help us expedite payment of any lost-time benefits that may be owed, as well as provide prompt payment of any medical bills related to your claim.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Phone Number	Employee E-mail
-----------------	------------------------------------------------------------------	-----------	--------------	-----------------

Mailing Address	City	State	Zip Code
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EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)
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Mailing Address	Phone Number	Employer FEIN
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City	State	Zip Code	Employer E-mail
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INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
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CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
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SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code
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EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease:
				<input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month
Insurer Type Code		List Normally Scheduled Days Off		
<input type="checkbox"/> I - Insurer <input type="checkbox"/> S-Self-insurer <input type="checkbox"/> Group Fund				

INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
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Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness	Body Part Affected
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How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address)	Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death
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Report Prepared By (Print or Type)	Telephone Number	Date of Report
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B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No	Average Weekly Wage: \$ _____ Weekly benefit: \$ _____	Date of disability:
Date of first Payment: _____ Compensation paid: \$ _____ or Date salary paid: _____ Penalty paid: \$ _____		
BENEFITS ARE PAYABLE FROM _____ FOR:		
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.		
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.		

C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this Form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation. If you need additional help, call your insurance company or self-insurer claims office.
3. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

B. NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct insurance company and their SBWC ID number.

Complete Section B, C, or D and file with the Board and send a copy of both sides of the Form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury, or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

C. NOTICE TO EMPLOYEE

This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a Form WC-14 Notice of Claim within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For information or assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free: 1-800-533-0682

Atlanta: (404) 656-3818

<https://sbwc.georgia.gov>

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys[®] network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.



If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions. If the claim is accepted, future prescriptions after this first fill may be subject to prior authorization.



Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.





Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.



Questions? Need Help?

1-866-599-5426

 	
WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM	
Society Insurance CARRIER _____ EMPLOYER _____	
INJURED PERSON NAME _____	
Please provide directly to Pharmacist SOCIAL SECURITY NUMBER _____ DATE OF INJURY (YYMMDD) _____	
Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com .	

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk

1-800-964-2531

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

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

HACEMOS MÁS SENCILLO QUE SE LE ABASTEZCA LAS RECETAS DE SU PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Persona lesionada:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. En la mayoría de los casos, la farmacia abastecerá la receta sin costo para usted.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo. Si el reclamo es aceptado, futuro recetas después de este primer vez llenando puede estar sujeto a autorización previa.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información que aparece a continuación y entregue este formulario al empleado.



Cómo encontrar una farmacia de la red

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para ubicar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.



**¿Tiene alguna pregunta?
¿Necesita ayuda?**

1-866-599-5426




WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Society Insurance
 PORTADORA _____ EMPLEADOR _____

NOMBRE DEL PERSONA LESIONADA _____

Please provide directly to Pharmacist
 NUMERO DE SEGURO SOCIAL _____ FECHA DE LA LESION (AAMMDD) _____

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

**Tmesys Pharmacy Help Desk
1-800-964-2531**

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

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.

Attending Physician's Return to Work Recommendations Record

Physician: Please fill out this form and fax it to 920-922-1071, attention:

Employee: Completed form must be returned to your employer **following each examination.**

Employer: When received, route this form to Society Insurance immediately.

Injury information

Employee name	Claim number	Date of birth	Date of injury/illness
Employer name	Employer address		Examination/treatment date
Brief diagnosis of injury (indicate clinical manifestation of condition to what body part or surface)			
Please check one: <input type="checkbox"/> Work Related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Undeterminable			

Patient has been advised of the following regarding return to work:

<input type="checkbox"/>	Return to work immediately, with no restrictions.
<input type="checkbox"/>	No return to work until: _____
<input type="checkbox"/>	Return to work with the following temporary restrictions beginning: _____ and ending: _____
<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 that 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.
<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.
<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"/>	Light Heavy Work. Lifting 75 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.

Number of consecutive hours patient can perform specified activity during an 8-hour work period

	6-8	4-5	1-3	0
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Weight-handling frequencies per hour

	15 or more	10-14	1-9	0
Lifting/carrying less than 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 10-20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 20-50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/carrying 50-100 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attending physician

Patient discharged? <input type="checkbox"/> Yes <input type="checkbox"/> No		Next scheduled examination/treatment date	
Comments and Notes			
Attending physician's signature		Date	Phone
Print Name		Address	
		Fax	

Supervisor Incident Report

Important: The manager or supervisor should complete this form after the incident

Claim Number				
Injured worker's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number	Date of birth
Address			Phone	Date of hire
Job title and department			Date of injury	Time of injury
Was medical attention sought? <input type="checkbox"/> Yes <input type="checkbox"/> No	(If applicable) Name of facility or physician that provided treatment			Was (or will) a drug screen completed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Scheduled work week at time of injury	Hours	Days per week	Start time	End time
Injured worker's normal/usual schedule	Hours	Days per week	Start time	End time
Witnesses to the incident				
Injured worker's statement regarding the injury (list all circumstances and equipment involved)				
Part(s) of body affected				
Type of injury or injuries				
The answers I have provided to the above questions are true to the best of my knowledge.				
Injured worker's signature			Date	
Supervisor's signature			Date	

Witness Statement Form

Injured worker's name:	Claim number:
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Your information			
Name:		Address:	
Home phone:		Cell phone:	
Employer:		Job title:	

Incident information			
Date of incident:	/ /	Time of incident:	
What is your relationship to the injured worker?			
Did you see the incident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

What work was being performed when the incident occurred?

Please explain what you saw.

Where were you in relation to the injured employee when the incident occurred? Did you have a clear view of the incident?

Witness signature:		Date:	/ /
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How did the injured employee act after the incident? Did they say anything to you?

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Did the injured employee show you where they were hurt?

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Did you see anyone else who may have seen what happened? If yes, please include names and phone numbers.

--

Was anything said to you by anyone other than the injured employee? If yes, who said something? When did they say it? What did they say?

--

Did you discuss anything regarding the injury with anyone? If yes, who did you discuss it with? When did you discuss it? What did you discuss?

--

Did the injured employee ever mention any prior problems with the injured area to you? If yes, when did they mention it?

--

Witness signature:

--

Date:

/ /

--

Job Analysis

Employment Information

Employee name		Claim number	Employer name
Job title	Supervisor interviewed? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list supervisor name
Was the employee hired with any restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, explain the restrictions	
Typical work hours per week	Overtime? <input type="checkbox"/> Yes <input type="checkbox"/> No	Break? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list frequency

Body movements at work

	Rarely	Occasionally (1/3 or less)	Frequently (1/3 to 2/3)	Continuously (2/3 or more)	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vertical reaching at or above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending/stooping/squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling/kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Close-distance hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Near/far vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Describe the driving involved					
Weights handled (lbs.)	Item	Alone or assisted?	Push/pull/lift?	Times per day	Distance moved
1-10					
11-20					
21-50					
More than 50					

Hand coordination

Is the injured worker right or left handed? Right Left

Movement required	Tool/machine	Left	Right	Both
Fine manipulation		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand twisting		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power gripping		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple grasping		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical surroundings

<input type="checkbox"/> Work inside	Percentage performed inside:	<input type="checkbox"/> Work outside	Percentage performed outside:
Work around moving machinery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe _____	
Check each of the following that the employee comes in contact with:	<input type="checkbox"/> Strong odor	<input type="checkbox"/> Fumes	Describe fumes _____
	<input type="checkbox"/> Mist	<input type="checkbox"/> Steam	<input type="checkbox"/> Air conditioning <input type="checkbox"/> Dust
Additional comments or observations			

Signature	Date completed

Transitional Return to Work Log

Transitional return to work log

Claim Number	Injured worker's name	Supervisor
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Date	Hours Worked		Tasks performed	Comments regarding injured worker's tolerance of modified-duty tasks	Initials
	In	Out			
Sunday					Injured worker
					Supervisor
Monday					Injured worker
					Supervisor
Tuesday					Injured worker
					Supervisor
Wednesday					Injured worker
					Supervisor
Thursday					Injured worker
					Supervisor
Friday					Injured worker
					Supervisor
Saturday					Injured worker
					Supervisor

I clearly understand, take responsibility for, and acknowledge the limitations my physician has placed on me while participating in this temporary transitional work program.	Physician's name
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Injured worker's signature	Date
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Risk Control Services

Our customers call Risk Control when they have something pressing on their minds, whether it relates to employee safety or evaluating trends in their insurance claims. They look for honest, objective, experienced, and thoughtful advice to address their concerns. As a policyholder, you are entitled to use Risk Control Services to help you control your workers compensation exposures.

We help our customers identify and evaluate hazards that might cause insurance losses or otherwise disrupt their business. We use our broad experience in risk control to recommend business solutions to our customers and assist them in avoiding or mitigating these potential losses.

These are our fundamental principles:

Use a collaborative and consultative approach

By working with our customers, we develop a fact-based view of the hazards affecting their business and provide consultative advice to successfully eliminate the hazards.

Use our broad expertise to provide superior value

We rely upon the technical diversity of our people - not a single consultant - to provide our customers with superior service.

Build sustainable improvements for our customers

We provide educational materials and value-added services that build knowledge and support for the customer to sustain their risk control program over the long term.

Build a trusting relationship

We want to earn the trust of our customers and agency partners. We do this by consistently providing professional service with absolute integrity.

Below is a brief overview of the many value-added services available through Risk Control.

- OSHA 10-hour and 30-hour training
- Forklift training
- Safety video library
- Hazard identification
- Safety program development
- Ergonomic assistance
- Review of machine guarding procedures
- Onsite visits
- Customized training
- Safety handouts
- Safety recommendations
- Claims analysis

If you have any questions or desire assistance in controlling your accident and illness exposures, please call our Risk Control Services department at 888-576-2438. Many of our resources are immediately available for your review in the Risk Control section of societyinsurance.com.