If you become injured at work

1. **If it's an emergency, call 911** or have someone take you to the nearest emergency facility.
2. **Report the injury to your supervisor immediately**, even if it seems minor.
3. **Call the SFM Work Injury Hotline at (855) 675-3501**, with your supervisor to report the injury. If you're unsure whether to get medical treatment, you'll be able to talk with a nurse.
4. **Provide your supervisor or claims coordinator with all requested information.** Injuries must be reported promptly and accurately for insurance purposes.

If you have questions about work injuries, see your supervisor or workers' compensation claims coordinator.

Claims coordinator: Debbie Wiirre

Phone: 218-744-7700

The following may be needed for identification purposes when calling the hotline.

Employer name: Rock Ridge Schools

Location name/address: 1405 Progress Pkwy

Virginia MN 55792

Policy number: 195385.201

sfmic.com

SFM®
The Work Comp Experts

ph-125-0220

WORKERS' COMPENSATION

SFM
The Work Comp Experts®

Insurance identification form

This form identifies SFM as your insurer for the work injury, and gives medical providers information on where to send bills.

Empleado: Este formulario identifica a SFM como su aseguradora para la lesión laboral y les brinda a los proveedores médicos información sobre dónde enviar las facturas.

Entregue este formulario a su proveedor de atención médica.

Employer: Please fill out the information below and give this sheet to your employee to take along on medical visits. Make sure the date of injury matches the date on the First Report of Injury.

Employee: Please give this form to your health care provider.

Fold

Cut around dotted line

SFM **Insurance identification information**

Employee: _____

Date of birth: _____

Date of injury: _____

Employer: Rock Ridge Public Schools

Policyholder number: 195385.201

Claim number: _____

Employer contact: Debbie Wiirre

Contact phone number: 218-744-7700

Send medical bills and records:

Electronically through Jopari Solutions using payer ID J1553 (Visit jopari.com or call (866) 269-0554 to sign up or learn more)

By mail to SFM Companies
P.O. Box 9416
Minneapolis, MN 55440

Payment will be provided according to the state's workers' compensation treatment parameters and payment rules for accepted workers' compensation claims. Call SFM for authorization on all surgeries, medical imaging, durable medical equipment and any treatment that departs from the state's treatment guidelines.

(800) 937-1181 | **sfmic.com**

Fold

Contact SFM at (952) 838-4200 or (800) 937-1181 or through sfmic.com.

ROCK RIDGE
SCHOOL DISTRICT #2909

1405 PROGRESS PKWY, VIRGINIA, MN 55792 | 218.742.3900 | FAX: 218.742.3960 | WWW.RRPS.ORG

Date: _____

Employee Name: _____

Employee Date of Birth: _____

Dear Physician:

Our organization provides alternate duty work to its employees who become injured. We strive to return injured employees to work as soon as they are medically able, and within their medical restrictions, with the goal of helping them heal and return to their regular jobs.

Current positions with the school district can be modified to accommodate the medical limitations of injured employees by altering specific tasks, reducing work hours, or modifying workstations and equipment.

If medical restrictions are appropriate for the employee above who you are treating, and if you have questions about the modified work to accommodate those restrictions, please call Debbie Wiirre, Human Resource Specialist, at 218-744-7700.

In order to help facilitate a smooth and safe return to work, please complete the attached Work Ability and Return to Work form or a similar document.

Thank you for working with us to help our employees return to work.

Sincerely,

Debbie Wiirre
Human Resource Specialist

Enclosures

WORK ABILITY/ RETURN-TO-WORK

SFM
The Work Comp Experts®

Send itemized medical billings and records to:
SFM Companies, PO Box 9416, Mpls, MN 55440
Fax: (952) 838-2000 Phone: (800) 937-1181

Send this completed form with the employee.

EMPLOYEE	HEIGHT	WEIGHT	DATE OF BIRTH
EMPLOYER			**DATE OF INJURY/ILLNESS**

DIAGNOSIS	ICD-10 CODE

History, mechanism of injury, and findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes,_____%

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached_____

RETURN TO WORK

☐ Return to work with ***no limitations*** on _____/_____/_____
MO DAY YR

☐ Return to work ***with limitations*** on _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

_____ **has light-duty work available. Please call** _____ at ( ) _____ **if you plan to take this employee off work.**

☐ Unable to work from _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

EMPLOYEE'S CAPABILITIES

BODY PART AFFECTED: ☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot
☐ Other _____

SIDE AFFECTED: ☐ Left ☐ Right ☐ Both

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Lift/Carry					
0-9 lbs	☐	○	○	○	○
10-19 lbs	☐	○	○	○	○
20-29 lbs	☐	○	○	○	○
30-39 lbs	☐	○	○	○	○
40-49 lbs	☐	○	○	○	○
No lift from floor	☐	○	○	○	○
Push/Pull without resistance					
0-19 lbs	☐	○	○	○	○
20-40 lbs	☐	○	○	○	○
> 40 lbs	☐	○	○	○	○
Bend	☐	○	○	○	○
Twist/turn	☐	○	○	○	○
Kneel/squat	☐	○	○	○	○
Sit	☐	○	○	○	○
Stand/walk	☐	○	○	○	○
Ladder/stair climb	☐	○	○	○	○

Hand, wrist and shoulder activities

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Avoid prolonged, repetitive or forceful:					
Gripping/grasping	☐	○	○	○	○
Repetitive wrist motion	☐	○	○	○	○
Reaching:					
Above shoulder	☐	○	○	○	○
At shoulder height	☐	○	○	○	○
Below shoulder	☐	○	○	○	○

Restrictions (circle):
Keyboarding (hrs/shift) 0 1-2 3-4 5-6 7
Writing (hrs/shift) 0 1-2 3-4 5-6 7
Total spread out evenly over shift at_____intervals

Change positions every
☐ As needed
○ Half hour
○ One hour
○ Two hours
☐ Worksite stretches, i.e., per handout
☐ Exercises ☐ Other_____

Comments

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every_____
☐ Medication_____
☐ Ice_____ min._____ ☐ Heat_____ min._____
☐ Splint/brace_____
☐ Referral_____

*Follow-up appointment scheduled for*_____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

CLINIC	CLINIC ADDRESS	LICENSE / REGIS.#	DATE OF EXAM
HEALTH CARE PROVIDER NAME (PRINTED)	HEALTH CARE PROVIDER SIGNATURE	PHONE	FAX