EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee.
Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department.
Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
http://www.dwd.wisconsin.gov/wc
e-mail: DWDDWC@dwd.wisconsin.gov

Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].
(**Please read the instructions on page 2 for completing this form**)

EMPLOYEE

Employee Name (First, Middle, Last)	Social Security Number	Sex	Employee Home Telephone No.
	- -	☐ M ☐ F	( ) -

Employee Street Address	City	State	Zip Code	Occupation
			-	

Birthdate	Date of Hire	County and State Where Accident or Exposure Occurred?

EMPLOYER

Employer Name	WI Unemployment Ins. Acct No.	Self-Insured?	Nature of Business (Specific Product)
GrapeTree Medical Staffing, L.L.C.	192892-000-5	☐ Yes ☐ No	healthcare staffing agency

Employer Mailing Address	City	State	Zip Code	Employer FEIN
2501 Boji Bend Drive, Suite 100	Milford	IA	51351	421512013

Name of Worker's Compensation Insurance Co. or Self-Insured Employer	Insurer FEIN
Amtrust	-

Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer	TPA FEIN
	-

WAGE INFORMATION

Wage at Time of Injury	Specify per hr., wk., mo., yr., etc.	In Addition to Wages, Check Box(es) if Employee Received:		
$	Per:	☐ Meals	No. of Meals/wk.	
		☐ Room	No. of Days/wk	
		☐ Tips	Avg. Weekly Amt. $	

Is Worker Paid for Overtime? ☐ Yes ☐ No If Yes, After How Many Hours of Work Per Week?

For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.

No. of Weeks:	Gross Amount Excluding Tips: $	If Piece-Work, No. of Hrs. Excluding Overtime:

	Start Time	Hours Per Day	Hours Per Week	Days Per Week
Employee's Usual Work Schedule When Injured:	: ☐ AM ☐ PM			
Employer's Usual Full-Time Schedule for This Type of Work at Time of Employee's Injury:				

Part-Time Employment Information:	Are there Other Part-Time Workers Doing the Same Work With the Same Schedule? ☐ Yes ☐ No If yes, how many?	Number of **Full-Time** Employees Doing The Same Type Of Work:

INJURY INFORMATION

Injury Date	Time of Injury	Last Day Worked	Date Employer Notified	
	: AM : PM			☐ Date Returned to Work
				☐ Estimated Date of Return

Did Injury Cause Death?	Date of Death	Was This a Lost Time or Other Compensable Injury?	Did Injury Occur Because of:		
☐ Yes ☐ No		☐ Yes ☐ No	☐ Substance Abuse	☐ Failure to Use Safety Devices	☐ Failure to Obey Rules

Was Employee Treated in an Emergency Room? ☐ Yes ☐ No Was Employee Hospitalized Overnight as an In-Patient? ☐ Yes ☐ No

Name and Address of Treating Practitioner and Hospital:

Case Number from the OSHA Log:

Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.

What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)

What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)

Report Prepared By	Work Phone Number	Position	Date Signed
	( ) -		

SEND REPORT IMMEDIATELY - DO NOT WAIT FOR MEDICAL REPORT

EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

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 Employee:

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. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, 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

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust ☐orth America
CARRIER/TPA EMPLOYER

INJURED WORKER 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. #
GROUP	FF		

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

Employer:

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

tmesys®

IMP14-1614-109-FFWG

OPTUM®

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL 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 su 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.

Empleado lesionado:

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. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

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.

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

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL FECHA DE ALA 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. #
GROUP	FF		

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

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

□ e at the AmTrust Group, are convinced that an employer □ho provides light, or restricted □or□for injured employees, enjoys numerous □enefits. This is not just an opinion, it□s something □e see day in and day out. Consider□

- □nless an injured □or□er returns to the □or□place □ithin □0 days, chances of him□her ever returning drop dramatically. □resulting in a very e□pensive permanent disa□ility situation.□
- After □ months a□ay from the □or□place, only 50□ chance of return.
- After 12 months, only a 10□ chance of return.

Some Return-to Work Benefits Include□

- □Test□of malingering potential. Injured employees □ho refuse light duty are more prone to □eing malingerers.
- Opportunity for employer to demonstrate true concern for □or□ers□□ell-□eing.
- Promotion of reha□ilitation and recovery.
- Lo□er medical and reha□ilitation costs.
- Productivity.
- Morale improvement for the injured □or□er.
- A□ility for the employer to monitor the injured employee□s recovery progress.
- Decrease of □ C claims costs, □ith resultant do□nstream □ C premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception□*We've already got too many "programs" around here, and don't need any more paper*.

Truth□□ hile it is true a □ritten, planned program □or□s □est, in many cases a Light Duty □program□can □e nothing more than a management understanding of the □enefits and principles of Return-to-□ or□, ho□ it □or□s, and the commitment to □just do it□, □hen light-duty recommendations are made □y □ C physicians.

Misconception□*It will get me into an Americans With Disabilities (ADA) "situation".*

Truth□Light-duty and ADA □reasona□le accommodation□are t□o entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disa□ilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions re□uire accommodating only one or t□o factors, such as □no lifting over 10 pounds□, or the li□e. In many cases, if you □rea□the jo□s do□n into individual **tasks**, you□ll see that only one or t□o tas□s □ithin the employee□s normal jo□ are affected, and can □e handled in some other □ay.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth□Light duty is al□ays defined □y, and monitored □y the attending physician. An employee on light duty is periodically monitored □y the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception□*We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth□Any Local that o□jects to a Return-to-□ or□program should □e referred to its national □ody for guidance. Return to □ or□is universally recogni□ed as a very positive influence on an injured □or□er □as □ell as □enefiting the employer□ La□or unions, □hose major purpose for e□istence is the □enefit of the □or□ers they represent, should not only □tolerate□Return-to-□ or□programs, □ut enthusiastically promote, and assist in such programs□implementation and operation. It is strongly suggested that management approach la□or representatives to solicit their input, and assistance in ma□ing Return to □ or□a positive force in your □or□place.

Misconception□*I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth□Tal□to your □ C insuror□s claims professional. In many cases, states□□ C plans provide for □ma□e-up□pay to replace some, or all of the injured employees□decreased earnings. The goal of getting them □ac□to the □or□place, and doing some productive □or□is that important□

□MPLOY□R A□D I□S□RA□C□ CARRI□R I□STR□CTIO□S

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator □ithin seven □□□days after the date of a □or□-related injury □hich causes permanent or temporary disa□ility resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury re□uiring medical treatment, even though it does not involve lost □or□time.

For any □or□injury resulting in a **fatality**, the employer must also su□mit this form directly to the Department of □ or□force Development **within 24 hours of the fatality**.

An employer e□empt from the duty to insure under s. 102.28, □ is. Stats., and an insurance carrier administering claims for an insured employer are re□uired to su□mit this form to the Department of □ or□force Development □ithin 14 days of the date of □or□injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury □ill □e returned to the sender if the mandatory information is not provided.

Employee Section: Provide all re□uested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she □as injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal □mployer Identification □um□er □F□I□□for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours □or□ed for the jo□ □eing performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the □ody injured, the specific nature of the injury □i.e., fracture, strain, concussion, □urn, etc.□and the use of any o□jects or tools □i.e., sa□, ladder, vehicle, etc.□that may have caused the injury. Provide the name of the person preparing this report and the telephone num□er at □hich they may □e reached, if additional information is needed. This form □as designed to include information re□uired □y OSHA on form 301. If this section is completed and retained, the employer □ill not have to complete the OSHA 301 form.

STATE OF WISCONSIN

DWD

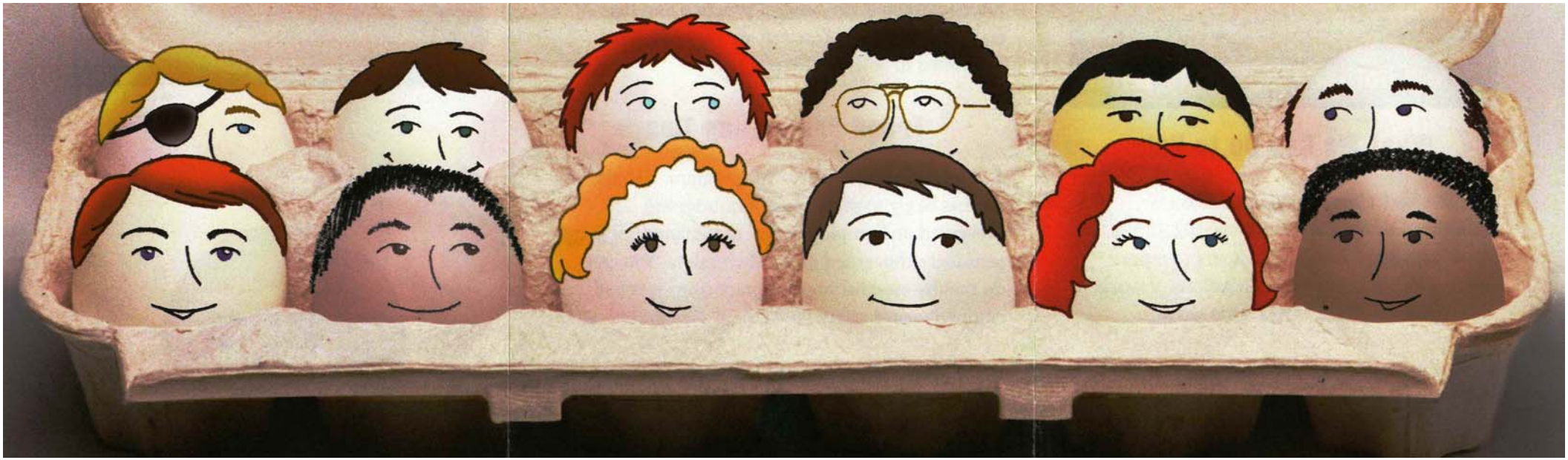
Department of Workforce Development

DIVISION OF WORKER'S COMPENSATION

We're protected by

WORKER'S COMPENSATION

Follow safety rules and *you'll* be protected from injury. But if you *are* injured at work, you're protected by benefits.



Report injuries to your supervisor immediately

- You don't need a lawyer to get benefits.
- You won't get in trouble for reporting an injury or making a truthful claim.
- Your supervisor will help start your claim.

Fraud hurts us all

Call the Fraud Hotline if you know about a false claim, (608) 261-8486. Or you can reach us via the internet at http://www.dwd.wisconsin.gov/wc Save everyone the added insurance costs and a possible reduction in wage increases.

Don't make a worker's compensation claim unless it's legitimate. You risk jail, a fine and/or job loss.

FRAUD HOTLINE

(608) 261-8486

WKC-10539-P (R.11/2014)

Prevent the Abuse of Worker's Compensation Claims

We Help Employers Fight Fraud

If you suspect a claim is fraudulent, or that it abuses the system, work with your insurance carrier to prepare evidence of the alleged fraud. Then report the case to:

Worker's Compensation Fraud Unit
201 E. Washington Avenue
P.O Box 7901
Madison, WI 53707-7901

For quick help, call the Fraud Hotline: (608) 261-8486

We Help Employers Fight Fraud

The Worker's Compensation Division is authorized by Wisconsin Statute 102.125 to work with employers and insurers to report, investigate, and prosecute allegations of worker's compensation fraud. Here's what we do:

- Work with you and your insurance carrier to determine if there is enough evidence to take the case to court.
- Refer the case to the local District Attorney's Office for prosecution when there is sufficient evidence of fraud. Cooperation from the Wisconsin Department of Justice and District Attorneys has been excellent.

PROVE IT!

Conviction of a fraudulent claim requires proof beyond a reasonable doubt of an intentional misrepresentation to secure benefits. Only the best documented cases succeed.

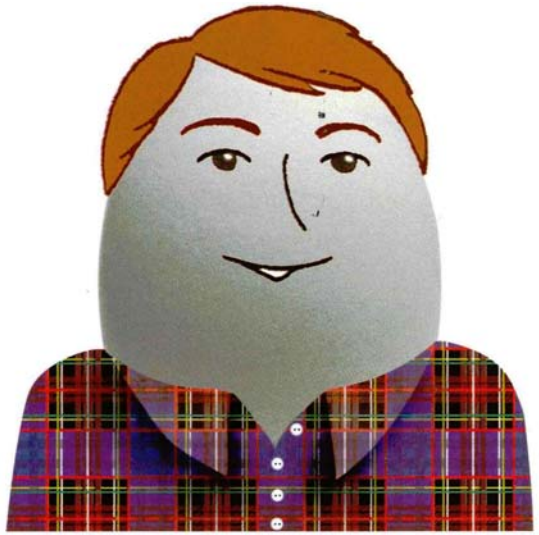
Prevention Is the Best Defense

A well-designed loss control program and the serious threat of legal action are very effective deterrents to making fraudulent claims.

Fraud Prevention Tips

1. Develop a first-class safety program. Claims are less likely to mushroom if injuries are prevented and employees feel that management is genuinely concerned about their safety. You can do that by establishing and practicing clear and comprehensive safety policies.
2. Establish strong accident investigation procedures. Injured employees and witnesses should be interviewed in person about the accident as soon as possible. Document all statements. Get a signed statement from the claimant.
3. Show concern for getting injured employees first-class medical evaluations and treatments.
4. Establish procedures for a clear understanding of essential information. Make sure the treating physician understands the nature of the job. Make sure the supervisor understands return-to-work limitations.
5. Make sure employees understand that false claims can be punished by terminations and criminal prosecution.

NOTE: Please use the poster on the reverse side to inform employees about worker's compensation fraud.



State of Wisconsin
Department of Workforce Development

Information for Employees on Wisconsin's Worker's Compensation

□ or□er's Compensation is a □enefit program that pays for medical treatment and □ages lost due to injuries or illnesses that happen at □or□.

What do you do if you are injured?

- Report any injury or illness to your employer as soon as possi□le. Provide as much detail and information a□out ho□ the injury happened and the nature of your injury. Your employer □ill report your injury to their insurance carrier or claims administrator.
- Get medical treatment as soon as possi□le. You have the right to choose any physician licensed and practicing in this state to treat your □or□-related injury or illness. Your employer□insurance carrier □ill have access to the medical records involved in the injury.

What does worker's compensation pay for?

- Medical treatment resulting from your □or□-related injury or illness.
- Compensation for □ages lost from the employer of injury including partial □enefits if you return to □or□ part-time or to a different jo□ at a lo□er rate of pay.
- Compensation for permanent disa□ilities resulting from the injury or illness.
- Vocational Reha□ilitation assistance to help you find other □or□ or train you if you cannot return to □or□ for your employer in suita□le employment.

What will happen when you file a claim?

- Your claim □ill □e promptly revie□ed to determine that your injury is □or□ related.
- Your employer□insurance carrier □ill pay your lost □age compensation, generally □ithin 14 days after your injury, or they □ill notify you that your claim has □een denied.
- If you disagree □ith the decision □y your employer□insurance carrier and cannot resolve a dispute, you may contact your attorney or the □ or□er's Compensation Division for information a□out your appeal rights, □hich may re□uire re□uesting a hearing □ith the □ or□er's Compensation Division.

Fraudulent Claims

Collecting □or□er's compensation □enefits □y intentionally misrepresenting, misstating, or failure to disclose any material fact is fraud. Fraudulent claims are su□ject to prosecution. All suspected violations □ill □e investigated. Anyone may report a potential fraudulent claim □y calling the □ or□er's Compensation Division at □□08□2□1-848□.

Questions and Contact Information

□ or□er's Compensation Division
P O Bo□ □901
Madison, □ I 53□0□-□901
Telephone□□08 2□□-1340

□ e□site□ http□□□□ □□.d□d.state.□i.us□□c□
□-mail□ d□dd□c□ d□d.state.□i.us
Fa□□ □□08□2□□-0394

If you have a disa□ility and need information in an alternate format, or need it translated to another language, please contact □□08□2□□-1340 voice or 1-8□□-2□5-3142 TTY.

□ □C-1430□-P □□. 08□2004□