

claim number:

Employee:

- Go to the doctor. Give the doctor the letter from Sound Native Plants along with your job description, both found in this packet. Have the doctor sign these papers and make sure they get back to the office.
- Get the claim number from the accident report form that you fill out at the doctor's.
Write it here in the upper right hand corner of this paper.
- Follow the doctor's advice. Get better soon so we can see your smiling face at the lunch table.
- Fill out an Incident Report Form. Get it back to us within 5 working days.

Employer:

- Make an individual claim file to keep copies of all paperwork relating to the claim. Save an internal copy of all paperwork sent to L&I.
- Create a "1st day" packet that includes the following items:
 - job description (preferably signed by the doctor).
 - employee's work history prior to Sound Native Plants (i.e. the original job application)
 - current payroll records (including the cost of health insurance premiums)
 - copy of internal incident report
 - copy of Accident Investigation report, if available
 - write claim number in large letters on the upper right corner of each page
- Mail this packet to

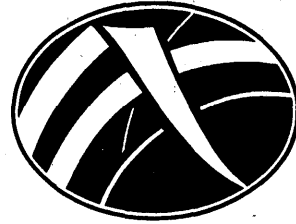
Department of Labor & Industries
Insurance Services Division
PO Box 44299
Olympia WA 98504-4299

claim number:

Employee's Incident Report Form

Instructions: Employees of Sound Native Plants may use this form to report all work related injuries, illnesses, or "near miss" events (which could have caused an injury or illness) – *no matter how minor*. This helps us to identify and correct hazards before they cause serious injuries. This form should be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when?	Employer:
Your signature (optional):	Date:



**SOUND
NATIVE
PLANTS**

NURSERY INSTALLATION CONSULTING

Dear Health Care Professional,

Sound Native Plants is dedicated to the health and well being of our employees and we wish to see them back at work as soon as possible. We are a small environmental restoration firm with a four-person installation crew. The crew performs duties around landscaping and construction sites.

Enclosed is a job description for our employee with room for your comments and recommendations. Please inform us of any limitations our employee will have in respect to their work.

Thank you for the best possible health care,

-Sound Native Plants

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claim number:

JOB DESCRIPTION

Job Title: Installation Crew Member

Employer: Sound Native Plants
PO Box 7505
Olympia WA 98507
(360) 352-4122

MACHINERY, TOOLS, EQUIPMENT: Full-sized pickup truck, wheelbarrow, cart, push-broom, lopper, pruners, shovel, mattock, tree shelters, weed mats, mallets, ground staples, erosion control fabric, landscaping rake, plant material

PHYSICAL DEMANDS

- Not applicable
- Seldom (1 - 10% of the time)
- Occasional (10 - 30% of the time)
- Frequent (30 - 70% of the time)
- Constant (over 70% of the time)

	Frequency	Comments
Sitting	Seldom	
Standing	Constant	
Walking	Frequent	
Driving	Occasional	
Lifting 10+ lbs.	Frequent	Repetitious lifting from waist to ground, or ground to waist
Carrying 10 lbs	Occasional	
Pushing/Pulling	Frequent	
Climbing Stairs/Ladders	Seldom	
Heights/Balancing	Seldom	Occasional ladder work
Bending at Waist	Constant	
Twisting at Waist	Constant	
Kneeling/ Squatting	Constant	
Crawling	Occasional	
Reaching Above Shoulder	Seldom	
Repetitive Arm/Hand Movement	Constant	

claim number:

FOR PHYSICIAN'S USE ONLY

- The injured worker can perform this job and can return to work on _____.
- The injured worker can perform this job on a part-time basis for _____ hours per day.
- The worker can be expected to return to regular duties by (date)_____.
- The injured worker can perform the described job but only with modifications as noted in Comment section below.
- The injured worker cannot perform this job based on the following physical limitations:

Comments:

Physician's Signature: _____

Date: _____