PENSER
North America, Inc.

PO Box 4047 ■ West Richland, WA 99353 ■ Phone 509-420-7290 ■ Fax 509-420-7289

Colville Confederated Tribe of Indians Worker's Compensation Claims Act Reporting Instructions

NOTICE TO TRIBAL GOVERNMENT AND ENTERPRISE EMPLOYEES AS EMPLOYEES OF THE CONFEDERATED TRIBES OF THE COLVILLE RESERVATION OR ITS ENTERPRISES, YOU ARE INSURED FOR ON-THE-JOB INJURIES UNDER THE TRIBAL WORKERS COMPENSATION CLAIMS ACT

If you are injured or sustain an occupational disease while at work, you may be entitled to benefits as provided by the Tribal Workers Compensation Claims Act, Chapter 6-15 of the Colville Tribal Code. **NOTIFY YOUR EMPLOYER/SUPERVISOR IMMEDIATELY OF ANY INJURIES, NO MATTER HOW SLIGHT**. If you fail to do so, you may NOT be entitled to any benefits under the CCT Workers Compensation Claim Act. In no event shall benefits be paid to a worker who failed to notify his or her employer within fourteen (14) working days after sustaining such work-related injury, excepting cases where an extraordinary reason prevented the worker from reporting the injury or occupational disease to the employer in a timely manner. **It is your responsibility to file a claim for benefits under the act with the administrator and/or Risk Management, by completing the CCT Workers Compensation Injury/Occupational Disease Application for Benefits.** You are required to file a claim for any injuries or occupational disease **no more than thirty (30) days** after you have knowledge thereof. It is your responsibility to obtain the necessary forms from the tribal website at https://www.colvilletribes.com/human-resources/ , request them by phone at 509.634.2845, email cct.benefits_workerscomp@colvilletribes.com or visit the Risk Management office in person.

Your exclusive remedy for any work connected injury or disease is through the tribal workers benefits system. **The state's workers compensation system has no authority to accept a claim from you related to employment by the Confederated Tribes of the Colville Reservation, a sovereign Indian Nation employer, which is exclusively under the jurisdiction of the tribal workers claim act.**

Please follow the instructions below when an injury/occupational disease occurs to ensure the claim is reported in a timely manner:

Employee Application for Compensation & Report of Injury or Occupational Disease

(Employee completes and reports incident to Supervisor immediately following the incident if possible)

Must be filled out in its entirety, If an area does not apply, address with "NA". If the application is incomplete this could delay benefits and medical coverage) please ensure that the description of the incident is detailed, to include the exact actions that were being performed at the time of the injury/occupational disease.
Submit a signed Job Description
Medical Release Form

Supervisor's Accident Report of Injury

(*Supervisor responsible for completing and submitting to Risk Management immediately following the reporting of the incident)*
Needs to be completed by immediate Supervisor. Supervisor must complete the form (signature and date completed required) and submit to the Risk Management Department immediately.
Must provide all approved SOP's and policies pertaining to the program/department

Physician's Initial Report

(Attending Provider completes)
Please provide a blank copy to the Physician/Provider who examines you initially. The Provider will complete the form, please ensure they provide you with a complete copy or fax the completed form to Penser North America at 509-420-7289 (this will assist the Claims Manager with determining claim allowance, diagnosis and what the treatment plan is going forward).

Activity Prescription Form

(*Attending Provider completes)*

Please provide a blank copy to the attending provider. This must be completed at every follow up visit and/or Hospital visit provided to Penser North America at 509-420-7289 or Risk Management at 509-634-2722, you can also email the completed form to laurah@penserna.com or brian.nanamkim@act@colvilletribes.com immediately following your appointment. A copy also needs to be provided to your Supervisor to determine if the work restrictions given (if any) can be accommodated by your Department.

YOU CAN EMAIL, FAX.OR VISIT RISK MANAGEMENT OR PENSER NORTH AMERICA WITH THE NECESSARY COMPLETED FORMS AT:

Brian Nanamkin, Risk Manager
Risk Management
Brian.Nanamkin.ACT@colvilletribes.com
P: 509-634-2845
F: 509-634-2722

Laura Hernandez, Sr. Claims Examiner
Penser North America
Laurah@penserna.com
P: 509-594-4796
F: 509-420-7289

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Employee Application for Injury or Occupational Disease Form

(Please complete the form below in its entirety – Indicate N/A if not applicable to ensure all questions are addressed)

APPLICANT INFORMATION

Emp. Name: _____ Mailing Address: _____
Phone/Cell: _____ Email: _____
Date of Birth: _____ S.S.N #: _____
Dependent(s) &
Marital Status: _____ DOB: _____
Dependent(s) & Dependent(s) &
DOB: _____ DOB: _____

EMPLOYMENT

Department: _____ Job Title: _____
Date of Hire: _____ Hourly Wage: _____
Work Schedule: _____ Work Hours: _____
Did you lose any time from work beyond date of injury / accident? (Yes) (No)

Last Day Worked: _____/_____/_____ | Date Returned to Work: _____/_____/_____

INJURY / ACCIDENT REPORT

Incident Date: _____ Incident Time: _____:_____ (A.M.) / (P.M.)
Incident Location: Grand Coulee Dam_____ Bodily Injury Location(s): _____
* Injury /accident was reported to Immediate Supervisor on (DATE) : ____/_____/_____
1.) Were you performing job duties? (Yes) – Provide detailed description below.
2.) Was the incident the fault of another employee? (No) | Name(s): _____
List any witnesses:
Part of body injured or exposed: Right Left
Describe in detail how your injury occurred:

_____
_____
_____

MEDICAL

Please complete this section if you received medical treatment for injury / accident

Physician Name/Clinic Name: _____
Address: _____
Phone: _____
Next follow up appointment/referred to: _____

Employee Signature: _____ **Date**: _____

DISCLAIMER & SIGNATAURE

I declare that the foregoing information & statement supplied are true to the best of my knowledge.
Medical Release Authorization: I hereby authorize my physician, hospital, agency, or organization to disclose to my employer or their representatives, any medical records or other information regarding treatment which has previously been furnished to me. NOTICE: Indian reservations are sovereign nations and are not subject to the state or federal workers' compensation laws. By completion of this form you are submitting to the sole jurisdiction of the tribe. NOTICE: Making or causing to be made any knowingly false or fraudulent material statement written or oral, or purposefully withholding material information in order to receive compensation is unlawful and will result in a denial of benefits, penalties, and/or prosecution.

Employee Signature: _____ **Date**: _____

IMMEDIATE SUPERVISOR SIGNATAURE

Supervisors Signature: _____ **Date**: _____

COLVILLE CONFEDERATED TRIBES WORKERS COMPENSATION

21 Colville Street | P.O. Box 150, Nespelem, WA 99155
P: (509) 634-2842 | F: (509) 634-2722

Colville Confederated Tribes Supervisor's Accident Report of Injury

Employment Status (circle all that apply):

Full time	Part time	Temporary
On-Call	Seasonal	Wex
Contract	Stipend	Summer Youth

Accident Classification (circle all that apply):

First Aid only	Death
Medical Treatment	Lost time

1. Name: _____ Home/Mobile Phone: _____
2. Department: _____ Occupation/Title: _____
3. Hourly rate of pay: _____
4. Date of hire: _____
5. Provide employees work schedule (hours per day/days per week)? _____
   If seasonal, give total weekly hours: _____ Regular days off: _____
6. Last date worked: _____ Location of incident: _____
7. Date and time of Incident: _____
8. Date and time incident was reported to Supervisor: _____
9. Date and time Supervisor reported to Risk Management: _____
10. Was the employee engaged in regular course of his/her duties at time of accident: YES NO
11. If NO, explain: _____
12. Provide description of accident/exposure: _____
    _____
    _____
13. Part of body affected: _____ Left Right

Please circle all that apply:

1.Inadadequately Guarded	1.Operating without authority
2.Unguarded	2.Operating at unsafe speed
3.Defective tools, equipment, or substance	3.Making safety devices inoperable
4.Unsafe design or construction	4.using unsafe equipment or equipment unsafely
5.Hazardous arrangement	5.Unsafe loading, placing, mixing
6.Unsafe illumination	6.Taking unsafe position
7.Unsafe ventilation	7.Working on moving or dangerous equipment
8.Unsafe clothing	8.Distraction, teasing, horseplay
9.Insufficient instruction	9.Failure to use personal protective devices
10. Other: _____	

14. Why was the unsafe act committed: _____
15. Why did the unsafe conditions exist: _____
16. What was the job assignment at time of accident: _____
17. List Witnesses (attach statements): _____
18. Guides to corrective action:

A. Unsafe acts
   Stop behavior Study the job Instruct (tell, show, try, check) Follow up 5. Enforce

B. Unsafe Conditions
   Remove Guard Warn Supervisor Training

C. If Supervisor can't handle, then recommend to:
   Boss Safety Committee Maintenance Follow up with: _____

19. Actions taken to prevent future injuries:
_____
_____

_____ _____ _____ _____

Immediate Supervisor's Signature **Date Received** **Risk Management Signature** **Date Received**

Return completed form to:

Penser North America, Inc.
PO Box 4047
West Richland, WA 99353

Fax: 509-420-7289

Activity Prescription Form (APF)

Billing Code: 1073M

General Info

Worker's Name:	Patient ID:	Visit Date:	Claim Number:
Healthcare Provider's Name (please print):		Date of Injury:	Diagnosis:

Required: Work status

☐ Worker is released to the job of injury (JOI) without restrictions (related to the work injury) as of (date): ___/___/___
(If selected, skip to "Plans" section below)

☐ Worker may perform modified duty, if available, from (date): ___/___/___ to* ___/___/___ (*estimated date)
☐ If released to modified duty, may work more than normal schedule

☐ Worker may work limited hours: ___ hours/day from (date): ___/___/___ to* ___/___/___ (*estimated date)

☐ Worker is working modified duty or limited hours

☐ Worker not released to any work from (date): ___/___/___ to* ___/___/___ (*estimated date)

☐ Poor prognosis for return to work at the job of injury at any date

Required: Measurable Objective Finding(s) (e.g., positive x-ray, swelling, muscle atrophy, decreased range of motion)

Required: Estimate what the worker can do at work and at home unless released to JOI

How long do the worker's current capacities apply (estimate)?
☐ 1-10 days ☐ 11-20 days ☐ 21-30 days ☐ 30+ days ☐ permanent

Capacities apply all day, every day of the week, at home as well as at work.

Worker can: (Related to work injury) A blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% (Not restricted)
Sit					
Stand / Walk					
Perform work from ladder					
Climb ladder					
Climb stairs					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach Left, Right, Both					
Work above shoulders L, R, B					
Keyboard L, R, B					
Wrist (flexion/extension) L, R, B					
Grasp (forceful) L, R, B					
Fine manipulation L, R, B					
Operate foot controls L, R, B					
Vibratory tasks; high impact L, R, B					
Vibratory tasks; low impact L, R, B					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	lbs	lbs	lbs	lbs	lbs
Carry L, R, B	lbs	lbs	lbs	lbs	lbs
Push / Pull L, R, B	lbs	lbs	lbs	lbs	lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐ Yes ☐ No
Modified duty available? ☐ Yes ☐ No
Date of contact: ___/___/___
Name of contact: _____
Notes:

Note to Claim Manager:

☐ May need assistance returning to work
New diagnosis: _____
Opioids prescribed for: ☐ Acute pain or ☐ Chronic pain

Required: Plans

Worker progress: ☐ As expected / better than expected ☐ Slower than expected (*address in chart notes*)

Current rehab: ☐ PT ☐ OT ☐ Home exercise ☐ Other (e.g., Activity Coaching) _____

Surgery: ☐ Not Indicated ☐ Possible ☐ Planned Date: ___/___/___ ☐ Completed Date: ___/___/___

☐ Next scheduled visit in: ___days ___weeks or Date: ___/___/___
☐ Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? ☐ Yes ☐ No ☐ Possibly
If you are qualified, please rate impairment for your patient
☐ Will rate ☐ Will refer ☐ Request IME
☐ Care transferred to: _____
☐ Consultation needed with: _____
☐ Study pending: _____

Req: Sign

☐ Copy of APF given to worker ☐ Discussed three key messages on back of form with patient

Signature: _____ ___/___/___ ( ) ___-___
☐ Doctor ☐ ARNP ☐ PA-C Date Phone

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Fax: 509-420-7289

Work Status Form

- ***Complete this form within 14 days each time you receive it.***
- ***Read the instructions on the back before completing the form.***
- ***Failure to return this form may cause benefit payment delays.***

Claim number
Date of request
Date of injury

Your work status:

☐ I didn't miss **any** work due to my work-related injury and/or disease.

☐ I'm **not** working and remain unable to work at **any** employment due to my work-related injury and/or disease since

|_|_|_|_|_|_|_|_|

This was the first complete day I didn't do **any** type of work – paid or unpaid – such as volunteer activities, self-employment, or caregiving services (COPES).

I returned to work on |_|_|_|_|_|_|_|_| **with** ☐ **employer of injury** ☐ **new employer** ☐ **self-employment.**

Self-employment includes but is not limited to licensed, unlicensed, and/or online business.

I'm now working:

☐ Regular hours ☐ Reduced hours

☐ Regular wages ☐ Reduced wages

Before returning to work, I didn't work at any employment due to my work related injury and/or disease from |_|_|_|_|_|_|_|_| **through** |_|_|_|_|_|_|_|_|

This includes any type of work – paid or unpaid – such as volunteer activities, self-employment or caregiving services (COPES).

I have applied for and/or received the following benefits:

☐ Yes ☐ No Unemployment

☐ Yes ☐ No Social Security

☐ Yes ☐ No Retirement

☐ Yes ☐ No Monetary assistance from another government agency

On the day I was injured, my employer was paying for and/or providing the following:

☐ Yes ☐ No Medical/Dental/Vision

☐ Yes ☐ No Housing

☐ Yes ☐ No Board

☐ Yes ☐ No Utilities/Fuel

☐ Yes ☐ No I am still receiving these benefits. If no, the last date covered: |_|_|_|_|_|_|_|_|

Has the legal custody of your dependent(s) changed? ☐ Yes ☐ No

Has your address or phone number changed? If so, write your new address or phone number below.

Name:	
Street address:	
City, state, zip code:	
Phone number:	

Your signature is required below.

By signing below, I certify that the information I am providing is true and correct. I understand that I must immediately notify my claim manager if my doctor releases me for any work, if I am incarcerated and under sentence, or if the custody of my children changes. I also understand that if on this form I intentionally make a false statement or fail to disclose information about my physical condition, ability to work, and/or work performed (paid or unpaid), I will be required to refund any benefits wrongfully obtained and I may be subject to civil and/or criminal penalties.

Worker name (please print)	Worker signature	Best contact phone number	Date

Work Status Form Instructions

This form is for payment of time loss compensation if you didn't work and are unable to work during the dates you indicate. It's important you read this form carefully and complete all sections that apply to you.

Minimum requirements for payment of time loss compensation:
- Medical certification from your attending provider with objective medical findings and restrictions.
- A Work Status Form which you complete to request benefits. You must complete this form each time you receive it.

Your work status:
- We need to know if you missed time from **any** work due to your injury.
- It's important to notify Colville Confederated Tribes if you're engaged in activity that includes, but isn't limited to volunteer work, self-employment or caregiving.
    - Volunteer work could include Red Cross, food bank, soup kitchen helper, coaching sports.
    - Self-employment could include online sales, photography, selling firewood, newspaper delivery.
    - Caregiving could include caring for disabled family, babysitting, COPES/DSHS (paid caregiving).

Return to Work:
- If you haven't returned to work, skip this section.
- If you returned to any type of work, complete this section.
    - This could include working for a different employer, self-employment or volunteer activities.
- If you missed time from **any** work, specify the dates you didn't work.
    - The start date is the first day you didn't work in any capacity.
    - The end date is the day before you returned to work.

- If you're working with reduced hours or wages, you may qualify for Loss of Earning Power benefits. Please provide your Claims Examiner with copies of your timecard.

Other benefits:
- If you have applied for, or are receiving retirement, social security, etc., this may affect your time loss benefits.
- Monetary assistance from another government agency could include DSHS TANF.

Employer provided benefits on the date of injury:
- This information is needed to determine the current status of the employer benefits provided to you on the date of injury. For example, this could include your employer contribution to health care benefits.
- If you aren't continuing to receive the benefit(s), your time loss compensation amount may be affected.

Custody of dependents:
- Your dependent's portion of time loss compensation must be paid to the legal custodian.
- If the custody changes, L&I will need a copy of the legal paperwork and the current address for the legal custodian.

Change of address:
- If your address has changed, please provide your new address here.
- If not, leave this section blank.

Signature:
- Your signature is required for consideration of time loss benefits.
- By signing this form you're confirming the information you've provided is correct.

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COLVILLE CONFEDERATED TRIBES WORKERS' COMPENSATION TRAVEL REIMBURSEMENT FORM

You are entitled to reimbursement for medical treatment and traveling expenses incurred as a result of your industrial injury, such as mileage and parking fees. Mileage fees are reimbursed at the current state's reimbursement rate.

Note: Your starting point and destination point must have an address.

Date of appointment:	Reason of appointment/Providers name:	Address traveling from:	Address traveling to:	Mileage - Round trip
Associated expenses				
Parking				

PAYMENT WILL NOT BE ISSUED IF THE REQUEST IS RECEIVED OVER (1) YEAR FROM THE DATE OF APPOINTMENT/TRAVEL.

Please provide a completed copy to:

Laura Hernandez, Sr. Claims Examiner
PO Box 4047
West Richland, WA. 99353
Laurah@penserna.com
Or by Fax at 509-420-7289