

[Online Injury Reporting Tool for Workplace Injuries: How to Gain Access, Log In and When to Report a Workplace Injury](#)

Supervisors are an employee's first point of contact for incidents at work and should assist the employee in obtaining prompt medical attention when they have a work-related injury or illness. Documentation for the injury should be completed and submitted within 24 hours.

For every workplace incident, whether it is an injury/exposure, illness, incident, or near miss:

- An Accident / Incident Investigation Report ([AIIR form](#)) form must be completed and sent to Safety and Health Safety.Health@sonoma-county.org
 - The AIIR Form and Directions are located on the County's website: <https://sonomacounty.ca.gov/administrative-support-and-fiscal-services/human-resources/forms>
- Near Misses only require an AIIR form
- Incident only that are non-injuries, non-exposures where the employee does not need any sort of medical attention only requires an AIIR form
- If an employee wants an incident only "on the record" and requests a work comp claim form, complete the AIIR form and follow the directions below for the Online Injury Reporting Tool.
- If an employee doesn't want to file a workers' compensation claim but needs first aid at the work site (band-aid, ice pack, etc.), complete the AIIR form and follow the directions below for the Online Injury Reporting Tool. Any incident that is first aid or beyond must be filed with our workers' compensation administrator in the event the employee needs further medical attention or changes their mind about filing; this way, there are no delays in benefits.

Any workplace incident that results in an event or exposure in the work environment that either causes or contributes to the resulting condition or significantly aggravates a pre-existing condition will be reported on a supervisor report through the [Online Injury Reporting Tool](#).

- Any reported or known workplace exposure—airborne contaminants, blood-borne pathogens, harmful physical agents, toxic materials, reaction to job-related vaccine, etc. must be reported through the Online Injury Reporting Tool: www.intercareins.com

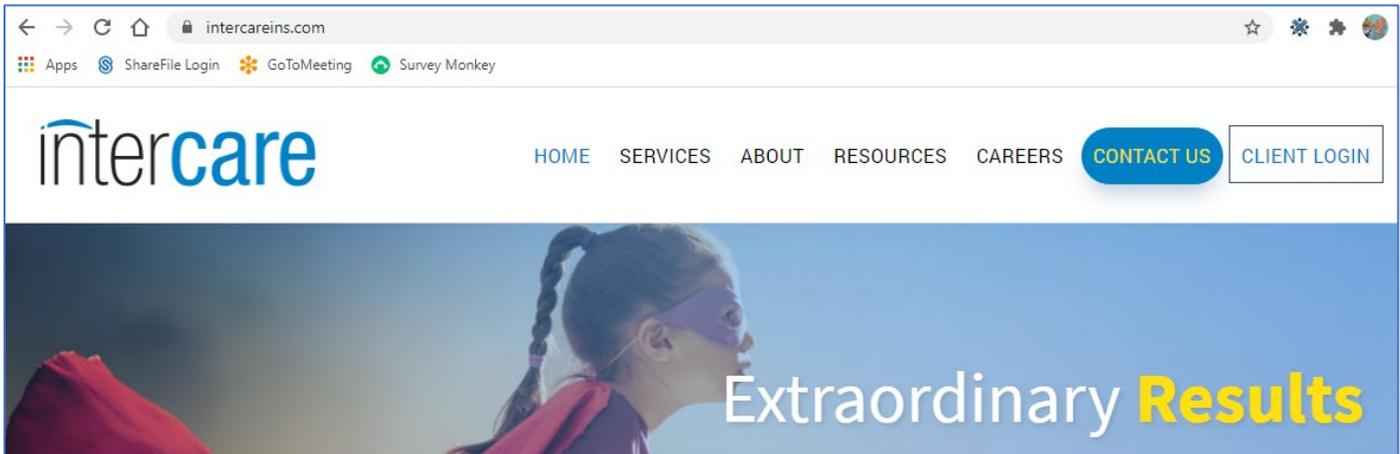
- Any reported or known workplace physical injury that is first aid and beyond must be reported through the Online Injury Reporting Tool: www.intercareins.com
- Any reported or known workplace injury where the employee has sought medical care, even if an occupational health provider did not provide the medical care, must be reported through the Online Injury Reporting Tool: www.intercareins.com

In cases where it is not possible to report the injury through the Online Injury Reporting Tool, Supervisor Reports of Injury/Illness forms may still be completed by hand and emailed to the work comp email box: workcomp@sonoma-county.org

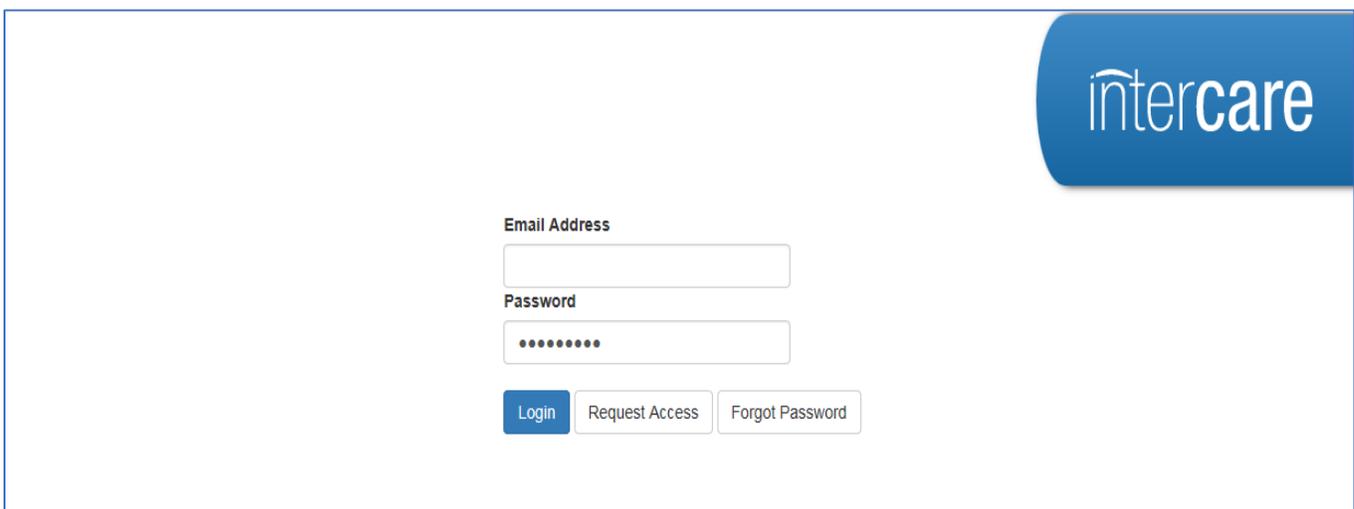
To help expedite the claims process for our employees and prevent unnecessary delays, all departments should use this sustainable online injury reporting tool whenever possible.

Online Injury Reporting Tool Directions:

- Visit Intercare’s Website: www.intercareins.com
- Click on the “Client Login” button to access the login page.



- Logging in for the first time
- Request access by selecting the “Request Access” button
 - Otherwise enter in your email address and password
- If you have forgotten your password you can select the “Forgot password” button



If you have selected the “Request Access” button on the login page you will be directed to this form.

Email Address

First Name

Last Name

Phone Number

Company

Job Title

Employer

Carrier

Additional Information



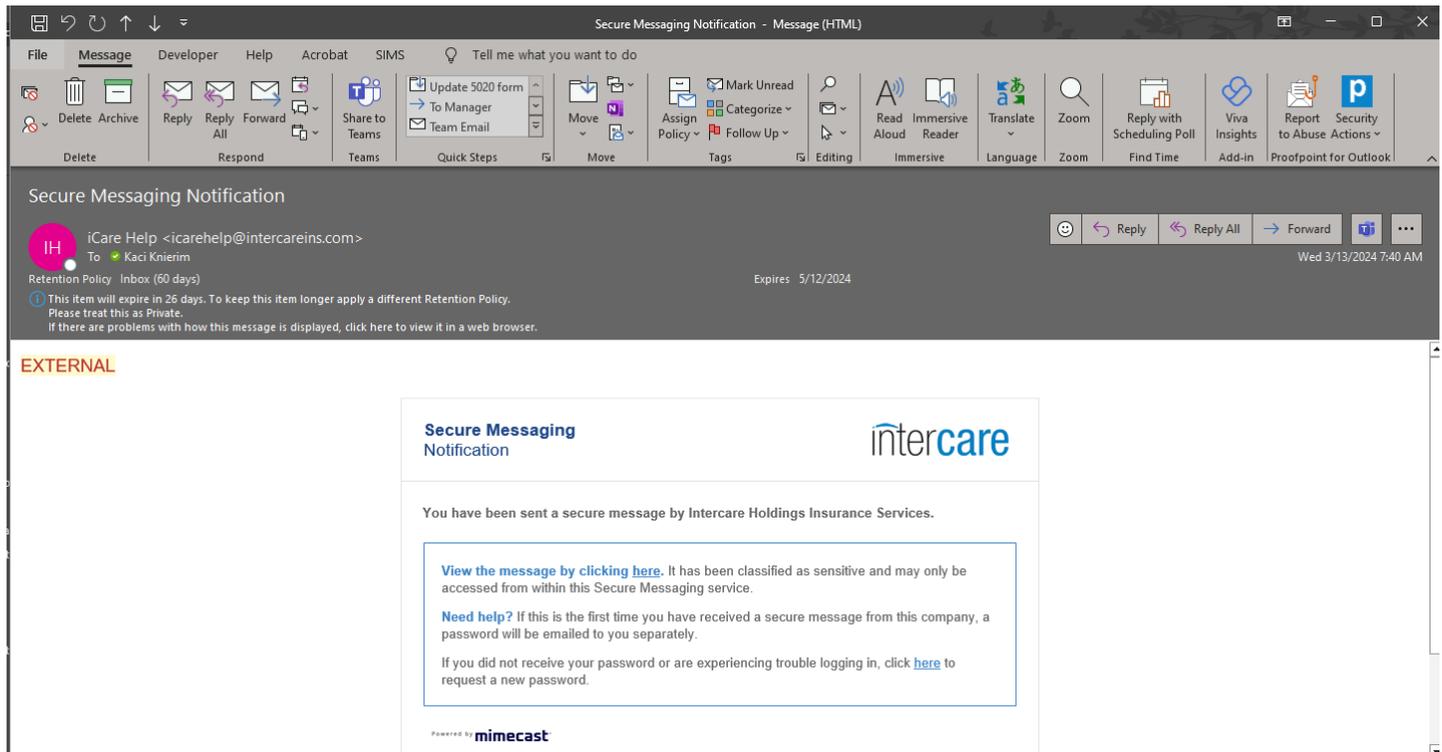
- Please enter your work email address.
- Your email address will be your user ID, and all communications through our website will be directed to this email address, including new claim confirmations and password re-sets
- If your email address changes during the course of your employment, please notify the workcomp email box at workcomp@sonoma-county.org immediately so this information can be updated with Intercare

- All requests for a login are validated by Intercare’s account management team.
- To expedite the validation and set up process, please follow the guideline above for Company (Sonoma County), Employer (Your Department—i.e. DHS, HSD, SHF, CDC, WTR etc) and Carrier (Intercare),
- When you are ready to submit the form, select the blue “Request Access” button at the bottom of the form to submit your request.

Once you request your login, Intercare’s IT Department will set-up your appropriate access and send you your login credentials via a secure email from icarehelp@intercareins.com. You will need to click on the link in the email to get your password. Below is a sample of the email that you will receive.

****You may need to log into your Outlook 365 to see the message. If the message from ICare Help has not shown up in your Outlook Desktop Version within 48 hours, please log into Outlook 365:**

The default OWA link is: "<https://outlook.office365.com/mail/>" **However - what I always find easiest to remember: just go to "office.com" in your browser** - it should automatically log in with your Sonoma County credentials if you're on a County computer (otherwise, log in with your current County email/password)



Change Password

- If you need to change your password or contact information, Click on the gear icon in the upper right corner of the screen, next to your email address.



- Here you can update your login profile and change your password.
- Remember to press the “Save” button when you are done.

<p>Email Address</p> <input type="text" value="aelliott@intercareins.com"/>	<p>Company</p> <input type="text" value="Intercare"/>
<p>First Name</p> <input type="text" value="Amanda"/>	<p>Job Title</p> <input type="text" value="Account Manager"/>
<p>Last Name</p> <input type="text" value="Elliott"/>	<p>Carrier</p> <input type="text"/>
<p>Phone</p> <input type="text" value="(818) 459-8214"/>	<p>Employer</p> <input type="text" value="Intercare Holdings Insurance Services, Inc."/>
<p>Save Cancel Back</p>	<p>Change Password</p>

Reporting a New Claim

- **1st screen—Pick Incident date, then click “Next”**
 - **Incident date** is the date the *employee* knew of the injury, which could be the day they are telling you as it just happened or the day the employee went to their doctor and they discovered they had a workplace injury

- **Cumulative/Ergonomic/Repetitive Motion Injury:** An ergonomic, repetitive motion or cumulative trauma injury is caused by repeated actions or activities over a period of time. It is usually not possible to determine the exact date an ergonomic injury began. Therefore, the method to establish the “Date of Injury” for an ergonomic injury for reporting and recordkeeping purposes is to determine which of the following occurred first:
 - The date the injury was first reported, or
 - The date of diagnosis by licensed medical professional, or
 - If the employee is currently off work, the first day of lost time due to this injury.
 - These events could all happen on the same day, but, in most circumstances, one will occur before the other(s). Confirm which of these occurred first, and enter the date that event as the “Date of Injury”.
- **Re-injury:** If this is believed to be a reoccurrence of a previous injury which healed and resolved, clearly note this in section 5 that this is believed to be a “re-injury” and enter the date (month, day, and year) the body part was re-injured.

Pick Incident Date

Back
Next
Cancel

January 2021						
Su	Mo	Tu	We	Th	Fr	Sa
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Policy DEMO-2014

Jurisdiction California

- **2nd screen--Pick Policy, then click "Next"**

Pick Policy For January 5, 2021

Back Next Cancel

Policy Number	Insured	Address	Phone	Business Nature
DEMO-2014	Demo Insured	123 Main Street		

1 - 1 of 1 items

Jurisdiction California

- **3rd screen--Enter in Employee Information, then click "Next"**
 - All fields that are outlined in blue are required to submit a new claim.
 - You cannot move forward until all blue fields are completed.
 - Address
 - City
 - State
 - Zip Code
 - Gender
 - Occupation
 - Under what class code of your policy were wages assigned
 - Pick closest Government class codes to your employees' job
 - 7722- Police, Sheriffs, Marshals, Animal Control, Correctional Offices, Fish and Wildlife
 - 8812- Libraries
 - 9410 Municipal, State, or other public agency employees, not engaged in manual labor
 - 9420 Municipal, State or Other public agency employees- all other
 - 9422, Road Districts or Departments
 - ****If you have information for non-mandatory fields, it is recommended you provide that information now.** Otherwise, the claims team will need to follow-up with you to collect missing information at a later date.

Employee Information

[Back](#) [Next](#) [Cancel](#)

First Name

Karen

Address

124 Main St

Gender

Male Female Non-Binary

Middle Initial

City

required

Date of Birth

mm/dd/yyyy 

Last Name

Sinclair

State

Select State ▼

Date of Hire

mm/dd/yyyy 

Social Security Number

Zip Code

required

Occupation

Select Occupation ▼

Employee Number

Phone

Under What Class Code of Your Policy Were Wages Assigned?

Select Class Code ▼

Gross Wage

\$0.00 ▼

Usually Works

Hours Per Day	Days Per Week	Total Weekly
<input type="text"/>	<input type="text"/>	0

Employment Status at Time of Injury

Full-Time ▼

- **4th screen—Employer Information, then click “Next”**
 - This section will auto-populate required information based on your User Login ID
 - If you can confirm which division/unit/team the employee works for, **please complete this information in the highlighted fields now.**
 - Organization 1
 - Organization 2
 - Organization 3

Employer Information

Back Next Cancel

<p>Firm Name</p> <input type="text" value="Demo Insured"/>	<p>Address</p> <input type="text" value="123 Main Street"/>	<p>State Unemployment Account Number</p> <input type="text"/>
<p>Policy Number</p> <input type="text" value="DEMO-2014"/>	<p>City</p> <input type="text" value="Rocklin"/>	<p>Nature of Business</p> <input type="text"/>
<p>Organization 1</p> <input type="text" value="Resources Management"/>	<p>State</p> <input type="text" value="California"/>	<p>Type of Employer</p> <input type="text" value="Private"/>
<p>Organization 2</p> <input type="text" value="Roads & Bridges"/>	<p>Zip Code</p> <input type="text" value="95561-____"/>	
<p>Organization 3</p> <input type="text" value="Roads"/>	<p>Phone Number</p> <input type="text" value="(916) 555-1212"/>	

- **5th Screen—Incident Information, then click on Report Claim**
 - **All fields highlighted in blue** are required to submit a new claim.
 - You cannot move forward until all required fields are completed.
 - Unable to work for at least one full day
 - Yes if EE left in during their shift to go home or seek medical treatment
 - No, if EE completed their assigned shift
 - Date of Employer’s Knowledge of Injury/Illness
 - The date that the employee knew of the injury, which could be the day they are telling you as it just happened or the day the employee went to their doctor and discovered they had a workplace injury
 - Date Employee was Provided Claim Form
 - The DWC-1 form will be provided by the Disability Management Team, which will be provided 1 business day after the injury accrued.
Please date this section for the next business day.
 - If the incident happened on a Friday, please date this section for the next business day
 - If the incident happened on a day before a holiday, please date this section for that next business day
 - Unable to Work for at Least One Full Day?
 - Answer NO if
 - EE has continued working, no days missed because of injury
 - Answer YES if
 - If EE left during their shift
 - EE is calling out sick for their shift because of injury
 - EE has been off work, and is now reporting the injury to you
 - Still Off Work?

- Answer NO if
 - EE has continued working
 - EE has returned to work since injury
- Answer YES if
 - EE is off work

Incident Information

Back
Preview FROI
Report Claim
Cancel

<p>Incident Date</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="4/17/2024"/>	<p>Time of Injury</p> <input style="width: 90%; border: 1px solid #ccc;" type="text"/>	<p>Time Began Work</p> <input style="width: 90%; border: 1px solid #ccc;" type="text"/>
<p>If Died, Date of Death</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="mm/dd/yyyy"/>	<p>Unable to Work For At Least One Full Day?</p> <div style="display: flex; gap: 5px;"> <input type="button" value="Yes"/> <input type="button" value="No"/> </div>	<p>Date Last Worked</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="mm/dd/yyyy"/>
<p>Date Returned to Work</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="mm/dd/yyyy"/>	<p>Still Off Work?</p> <div style="display: flex; gap: 5px;"> <input type="button" value="Yes"/> <input type="button" value="No"/> </div>	<p>Paid Full Wages For Day Of Injury or Last Day Worked?</p> <div style="display: flex; gap: 5px;"> <input type="button" value="Yes"/> <input type="button" value="No"/> </div>
<p>Salary Being Continued?</p> <div style="display: flex; gap: 5px;"> <input type="button" value="Yes"/> <input type="button" value="No"/> </div>	<p>Date of Employer's Knowledge of Injury / Illness</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="mm/dd/yyyy"/>	<p>Date Employee Was Provided Claim Form</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="mm/dd/yyyy"/>

- When completing the fields in this section of the form, it is important that you are as specific as possible to the best of your knowledge. The adjuster will be using this information to investigate and confirm the compensability of the claim.
 - Only the blue highlighted boxes are mandatory; all other boxes are optional, but if you have the information, please fill in the form.
 - If you are unsure and the box is not highlighted in blue, then please leave as is and move to the next question
- Lack of details in the claim could delay the claim process and benefits that may be owed to our employee.
- If you have additional comments regarding claim investigation or employee status, you can include them in the “additional comments” section.
 - Specify Injury / Illness, Part of body Affected, and Medical Diagnosis if available
 - Stress, Strain, Sprain, pain , cut, bruise, rash, scrape, soreness, etc.

- Body Part
 - Select from the drop-down list the most appropriate
- Nature of Injury
 - Select from the drop-down list the most appropriate
- Department Where Event or Exposure Occurred
- Provide the name of the building and location, AND the zip code of the location (e.g. loading dock, jail cell, cubicle, etc.) where the injury occurred. For injuries that occurred outside of County locations, provide the address.
- Equipment, Materials and Chemicals the Employee was Using when Event or Exposure Occurred
 - Describe the equipment, materials, or tool being used when the injury occurred
- Specify Activity the Employee was Performing when Event or Exposure Occurred
 - Describe the activity, job or task being performed.
 - Examples: Loading boxes; restraining a suspect; data entry; climbing a ladder; driving.
 - Did the event occur during overtime?
 - Was repetitive motion activity involved?
- How Injury/Illness Occurred, Describe Sequence of Events
 - Provide a full description of the events and circumstances related to the injury, including the events leading up to the injury and the medical response, if applicable.
 - Provide the sequence of events; the who, what, when, where, how. We are not looking for the fault of injury, just the facts of what happened to cause the injury
 - Remember to write in all the details. Leaving out information may severely compromise the initial claims investigation. This report is the foundation of all compensability investigations; an incomplete report can lead to a delay in benefits for your employee

Sample of form on next page.

Specify Injury / Illness, Part of Body Affected and Medical Diagnosis if available

required

Body Part

Select Body Part ▼

Nature of Injury

Select Nature of Injury ▼

Department Where Event or Exposure Occurred (e.g. shipping department, machine shop)

Equipment, Materials and Chemicals the Employee was Using When Event or Exposure Occurred (e.g. acetylene torch, farm tractor, scaffold)

Specify Activity the Employee Was Performing When Event or Exposure Occurred (e.g. welding seams of metal forms, loading boxes onto truck)

required

How Injury/Illness Occurred. Describe Sequence of Events. Specify Object or Exposure Which Directly Produced the Injury/Illness

required

- Boxes outlined in blue must be completed to submit the form
 - Location where event Occurred
 - Address
 - City
 - State
 - Zip code
- Please fill out all other boxes with the information if known
 - Boxes highlighted in blue must be completed
 - For all other boxes, please complete what you know
 - If you are unsure of the answer, please leave as is and move to next question

Initial Treatment

Emergency Evaluation, diag testing and medical procedures ▼

On Employer's Premise **Other Workers Injured?** **Employee Treated in Emergency Room?** **Hospitalized as Inpatient Overnight?**

<p>Location Where Event Occurred</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Physician</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Hospital</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Address</p> <input style="width: 100%; height: 20px;" type="text" value="required"/>	<p>Address</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Address</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>City</p> <input style="width: 100%; height: 20px;" type="text" value="required"/>	<p>City</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>City</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>State</p> <input style="background-color: #f0f0f0;" type="text" value="Select State"/> ▼	<p>State</p> <input style="background-color: #f0f0f0;" type="text" value="Select State"/> ▼	<p>State</p> <input style="background-color: #f0f0f0;" type="text" value="Select State"/> ▼
<p>Zip Code</p> <input style="width: 100%; height: 20px;" type="text" value="required"/>	<p>Zip Code</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Zip Code</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>County</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Phone</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>Phone</p> <input style="width: 100%; height: 20px;" type="text"/>

Additional Employer Comments

After all fields have been completed – scroll to the top and press the blue “Report Claim” button.

Incident Information

Incident Date

Time of Injury

Time Began Work

If Died, Date of Death

Unable to Work For At Least One Full Day?

Date Last Worked

Date Returned to Work

Paid Full Wages For Day Of Injury or

LAST SCREEN---SUBMISSION COMPLETED

- Once you have submitted the new claim, you will see a confirmation notice confirming that it was successfully submitted.

Your first report of injury (FROI) was successfully submitted.

- You can add attachments, such as:
 - Witness statements
 - Medical notes
 - Vehicle reports for car accidents
 - Report another Claim, or
 - Select “Home”, which will take you back to the claim submission page.
- **A list of submissions you have made under your login will be available – if you are interrupted while you are submitting a new claim, you can pick up where you left off and select “Continue.”**

aelliott@intercareins.com log off

New Claim

Claim Submissions

Claimant Name	Reported ↓	Status	
Amanda Farhang	January 15, 2021 12:06 PM	Incomplete	<div style="display: flex; gap: 10px;"> Continue Cancel Attachments (0) </div>
Test Testing	January 5, 2021 9:58 AM	Queued	<div style="display: flex; gap: 10px;"> Continue Cancel Attachments (0) </div>