WORKERS' COMPENSATION PACKET

DUPLICATE AS NEEDED

PLEASE POST COPY OF PACKET ON BULLETIN BOARD IN MAIN OFFICE FOR EASY ACCESS WHEN EMPLOYEE INJURIES OCCUR.

USE FOR EMPLOYEE INJURIES ONLY!

FROM THE OFFICE OF RISK MANAGEMENT

ANDREW DAVIS,
DIRECTOR OF RISK MANAGEMENT
6550 SEVEN OAKS, RM. #10
BATON ROUGE, LA 70806
PHONE: 225-929-8683
FACSIMILE: 225-929-8707

Updated (01/6/14)

EAST BATON ROUGE PARISH SCHOOL SYSTEM
WORKER'S COMPENSATION CHECK LIST
(Use For Employee Injuries Only)

NOTE: IT IS THE RESPONSIBILITY OF THE PRINCIPAL/SUPERVISOR AND/OR THE PRINCIPAL'S/SUPERVISOR'S DESIGNEE TO PROCESS AND MAIL THE APPROPRIATE DOCUMENTS TO THE OFFICE OF RISK MANAGEMENT WITH-IN 48 HOURS.

Forms:

6–11 AUTHORIZED MEDICAL FACILITY
Is Employee going to an authorized clinic? **Do Not Allow Employee to Drive!**
Clinics are preferred over emergency rooms.
Please utilize Occupational Medicine Clinic's **24 hour Emergency # 378-7884.**
Remind the Employee: Job related injuries **are not covered by health insurance.**

6-12 AUTHORIZATION FOR EMPLOYEE MEDICAL TREATMENT
Requires Principal/Supervisor/Designee's signature, and that they accompany the Employee to the Clinic.
Employee returns a copy to you with their work status.
Can the employee return to work?
If the employee has restrictions, please call and let's discuss.
Return a copy to the Office of Risk Management

6-12A **"HIPPA COMPLIANT"** – Authorization for Release of Information
Employee is to sign and return to the Office of Risk Management

6-13 RESTRICTED DUTY POSITIONS
Goes with the Employee to the Clinic to be given to the doctor.

6-14 ACKNOWLEDGEMENT OF UNDERSTANDING (Information about payments, ins., etc.)
Give to employee to read and sign.
Return original to the EBRPSS's Office of Risk Management.

6-15 SUPPLEMENTAL SICK LEAVE
Give to employee to read and sign.
Return original to the EBPRSS's Office of Risk Management.

6-16 WORKER'S COMPENSATION – EMPLOYER REPORT OF INJURY/ILLNESS
Complete as much information as possible.
Requires Principal/Supervisor/Designee's signature.
Return original to the EBRPSS's Office of Risk Management.

6-17 PRINCIPAL/SUPERVISOR'S INVESTIGATION REPORT – WORKER'S COMPENSATION
Requires an investigation of the accident.
Requires Principal/Supervisor/Designee's signature.

6-18 FIRST AID LOG
Record all employee injuries that did <u>NOT</u> require a doctor visit.
Submit monthly to the EBRPSS's Office of Risk Management (W/C).

From the Office of Risk Management
Andrew Davis, MPA, BS
Goodwood Center
6550 Seven Oaks, Rm. #10
Baton Rouge, LA 70806
Phone: 225-929-8683 Facsimile: 225-929-8707

EAST BATON ROUGE PARISH SCHOOL SYSTEM

AUTHORIZED MEDICAL FACILITIES FOR INITIAL TREATMENT OF ON THE JOB INJURIES

Thank you for your compliance with our workers compensation procedures:

1. Call EBRPSS's Office of Risk Management (225) 929- 8683 or 929- 8686 immediately after a decision has been made that an injured employee needs to go to the doctor.
2. Make sure the Workers Compensation Packet is completed and faxed to **(225) 929- 8707** before employee leaves site.
3. It is at the administrator's discretion on how the employee should be transported.
4. Injured employees should take form 6-12 of the Workers Compensation Packet (Authorization for Employee Medical Treatment) along with them to the doctor.
5. Remind the employee and the doctor's office that the injury is to be handled through Workers Compensation, **NOT** employee health plan.

Please direct all job related injuries to one of the following locations for initial treatment:

CLINIC	LOCATION	TELEPHONE
Health Remede Clinic***	3235 Perkins Road	225.387.3030
Total Occ. Medicine Clinic***	3333 Drusilla Lane	225.924.4460
Lake After Hours Clinic***	3333 Drusilla Lane	225.924.3906
After Hours Emergencies & Drug Screening	3333 Drusilla Lane	225.378.7884 (pager)
Ochsner Clinic Baton Rouge	2345 O'neal Lane 9001 Summa Avenue	225.761.5492
Emergency Rooms- IF NOT MEDICAL EMERGENCY USE CLINICS ABOVE* **		
Baton Rouge General	8585 Picardy Avenue	225.763.4000
Our Lady of the Lake	Entrance on Essen Lane	225.765.8826
Lane Memorial	6300 Main Street, Zachary	225.658.4335

REVISED 03/16

Form 6-11

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #

INDUSTRY CODE | EMPLOYER FEIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)

POLICY PERIOD

TO

CHECK IF APPROPRIATE

SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
- M MALE
- F FEMALE
- U UNKNOWN

MARITAL STATUS
- U UNMARRIED SINGLE/DIVORCED
- M MARRIED
- S SEPARATED
- K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE

\# OF DEPENDENTS

NCCI CLASS CODE

RATE PER: DAY WEEK MONTH OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE AM PM ( ) CANNOT BE DETERMINED

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO

WERE THEY USED? YES NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT
- 0 NO MEDICAL TREATMENT
- 1 MINOR: BY EMPLOYER
- 2 MINOR CLINIC/HOSP
- 3 EMERGENCY CARE
- 4 HOSPITALIZED > 24 HOURS
- 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

LWC-WC IA-1

IAIABC 2002

Form 6-16

EAST BATON ROUGE PARISH SCHOOL SYSTEM
PRINCIPAL/SUPERVISOR'S INVESTIGATION REPORT
WORKER'S COMPENSATION

Facility Name ______________________________

NAME OF EMPLOYEE ______________________ OCCUPATION ______________________

DATE OF HIRE ________________ HOW LONG IN OCCUPATION ______________________

DATE OF INCIDENT __________ TIME OF INCIDENT __________ DATE REPORTED __________

EXACT PLACE OF INCIDENT ____

NAME OF EMPLOYEE'S IMMEDIATE SUPERVISOR ______________________________________

WHERE WAS THIS SUPERVISOR AT THE TIME OF THE INCIDENT __________________________

DESCRIBE THE INCIDENT: Include a diagram on the back of this form if needed. Photographs [ ] Yes, [ ] No

____

____

____

DESCRIBE THE INJURY/DAMAGE ____

____

____

TREATMENT PROVIDED: [ ] None [ ] Onsite First Aid
[ ] Doctor [ ] Hospital Date Admitted ______________

WHAT CAUSED THE INCIDENT TO HAPPEN? (Do Not Say "Carelessness) ______________________

____

____

CORRECTIVE ACTION YOU HAVE TAKEN TO PREVENT THIS FROM HAPPENING AGAIN ______________

____

____

RECOMMENDATIONS TO OTHER FACILITIES TO AVOID SIMILAR ACCIDENTS ______________

____

WHAT SAFETY EQUIPMENT WAS IN USE? ______________________________________

INVESTIGATED BY: ______________________________ DATE ______________

PRINCIPAL/SUPERVISOR ______________________________ DATE ______________
Signature

This investigation must be completed within 24 hours of your first notification of the incident. Use the back of this form or additional sheets for supplementary information or witness statements. Notify the Office of Risk Management 225-929-8683 or 225-921-3103 immediately by telephone if medical treatment is required or if property damage is expected to exceed $500.00.

EAST BATON ROUGE PARISH SCHOOL SYSTEM

AUTHORIZATION FOR EMPLOYEE MEDICAL TREATMENT

The undersigned is an employee of the **East Baton Rouge Parish School System**. Please DO NOT administer drug screens unless authorized. Please send the completed original form with the employees so that he or she may return it to their supervisor. Send billings and authorization requests to FARA Insurance Services at 800.215.3272.

RELEASE OF MEDICAL RECORDS AND REPORTS AND
STATEMENT OF UNDERSTANDING OF RETURN TO WORK PROCEDURES
(This release includes verbal and written communications)

You or any physician, hospital, clinic or medical careprovider presently known or unknown to me, who may have or subsequently acquire such information are authorized to furnish to my employer, the East Baton Rouge Parish School System, its agents and or representatives, all information, facts and particulars including records, reports, medical history, physical condition, treatment rendered, X-rays, CT/MRI scans, or results of other diagnostic tests, diagnosis, prognosis, estimates of disability or recommendations for further treatment and statements of changes which may be requested and to furnish them copies of such.

This information is to be used for the purposes of evaluating and handling my claim for injury as a result of the accident on the date indicated below and for no other purpose, now or in the future. A photocopy of this form may be accepted with the same authority as the original.

I understand that I must report to my supervisor immediately upon being released by a physician to return to work with or withou restrictions. I also understand that I must return to work for the next regularly scheduled work shift after my release date. If I choose notto return, I will be docked up to six days leave after which I will be placed on leave without pay.

____________________	____________________	____________________
Employee Name (Please Print)	Social Security Number	Employee Signature & Date

TO BE COMPLETED BY SUPERVISOR OR PRINCIPAL (Please Print)

____________________	____________________
Nature of Job Related Injury (Body Part)	Date of Accident/Injury/Illness
____________________	____________________
Name of School or Facility	Signature of Principal or Designee

TO BE COMPLETED BY PHYSICIAN
******[This is a Legal Document Please Type or Print Neatly]******

Intial Diagnosis:

Disposition (check one)

[ ] Patient is able to return to work with no limitation.

[ ] Patient is able to return to work with the following restrictions: ____________________

[ ] Patient is NOT able to return to work: ____________Date of return visit:____________

[ ] Patient is to be hospitalized. If checked, call Risk Management at 929.8686 or 929.8683.

____________________	____________
Signature of Physician or Authorized Representative	Date

Physicians' Name and Address and Phone Number of Medical Facility ** Type or Print Neatly**

Revised 04/16 Copies: 1 (Original) Supervisor 2. Office of Risk Management (W/C) 3. Physician Form 6-12

EAST BATON ROUGE PARISH SCHOOL SYSTEM

RESTRICTED DUTY POSITIONS

ATTENTION: TREATING PHYSICIAN

The East Baton Rouge Parish School System has numerous ***Restricted Duty Positions*** for its employees who are disabled due to a job-related injury. The jobs

1. Require no lifting, bending, twisting or stooping and/or
2. Allow employees to sit, stand or walk as needed and/or
3. Require no overhead reaching and/or
4. Allow other reasonable accommodations.

Please contact the Office of Risk Management at 225.929.8686 prior to removing any employee from the job. This will allow us to consult as to whether or not accommodations can be made of which you would approve.

OFFICE OF RISK MANAGEMENT
Jocelyn Stewart, Risk Management Specialist
Phone: 225.929.8686
Fax: 225.929.8707

Authorization for Disclosure of Protected Health Information

I, ____________________ authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organizations(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified blow); all healthcare providers who have provided healthcare services to me.
2. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

Name **FARA, Inc. (F.A. Richard & Associates**

Address **400 E. Kaliste Saloom – Suite 4500, Lafayette, LA 70508**

Name ______________________________
(Employer)

Address ______________________________
(Employer's Address)

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):
Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments. I further specifically authorize the disclosure of psychotherapy notes, if any.
4. This information may be used by the carrier or representative to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) names above have taken action in reliance on this information.
6. This authorization expires 1 year from the date signed, or with the conclusion of my Workers' Compensation claim, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

______________________________ ______________________
Signed: Date:

Name: ______________________________

Address: ______________________________

Phone: ____________________ SSN: ____________________

____
Relationship or Authority of Personal Representative (if applicable)

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[1] Protected heath information (PHI) is health information that is created by a health care provider, health plant or health care clearinghouse which relates to 1) the past, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 48 C.F.R. 164.508.

[2] These laws apply to health plans, health care providers, and health care clearinghouses.

Form 6-12A

EAST BATON ROUGE PARISH SCHOOL SYSTEM

Acknowledgment of Understanding
Workers' Compensation
Wage Payments and Medical Benefits

1. It is the responsibility of the injured employee to return the completed **Authorization for Employee Medical Treatment** form to their supervisor within 24 hours.

2. Worker's compensation indemnity benefits are paid based on a percentage (66 2/3) of the employees' average weekly wage *up to a maximum amount* set by the State of Louisiana. Indemnity checks will be issued directly from FARA Insurance Services, our Third Party *Administrators (800-215-3272), after the* first week waiting period. **The first 5 working days (waiting period) will be taken from the employees' sick leave balance unless the employee notifies their payroll clerk otherwise.** Prescriptions and mileage related to the job injury are reimbursable.

3. The use of Sick Leave to supplement by-weekly indemnity benefits is optional. A **Worker's Compensation Supplemental Sick Leave** form must be completed and returned to the Office of Risk Management prior to the next scheduled payroll.

4. The use of health insurance in place of workers= compensation medical benefits is not permitted.

5. **Deductions** - Retirement Contributions and Health Insurance Premiums will not be deducted from the indemnity checks issued by FARA Insurance Services Employees must bring cash, personal check or money order made payable to the East Baton Rouge Parish School System each payroll period if,

    a) the employee **elects** to make retirement contributions on workers' compensation earnings, or regular full time earnings,
    b) the employee wishes to maintain health insurance. If premiums are not paid the employees' and dependents' health coverage will be terminated.
    c) **All Other Deductions** are the responsibility of the employee with the individual companies.

6. The employee must report to their supervisor two days before every payroll period. Notify the supervisor immediately upon being released by a physician to return to work for the next regularly scheduled work shift. If an employee chooses not to return, they will be docked up to six days of sick leave after which they will be placed on leave without pay.

7. Employees involved in an accident or the near miss of an accident on the job will be tested for illegal drugs and alcohol. Refusal to take this test is considered a positive test under state law and is a violation of Board Policy. Under the law, a positive drug or alcohol test voids all workers= compensation benefits.

I understand these procedures as they have been explained to me and have received a copy.

______________________________	______________________________
Employee Name (Please type or print)	Social Security Number
______________________________	______________________________
Employee Signature	Date

Please return this form to the **Office of Risk Management**

EAST BATON ROUGE PARISH SCHOOL SYSTEM
SUPPLEMENTAL SICK LEAVE
WORKER'S COMPENSATION

Please check the appropriate box and return this form to the Office of Risk Management (W/C).

While I am not working as a result of my job related injury, I request that the school system issue me a check for the difference in my normal pay minus Worker's Compensation Indemnity Benefits, and reduce my sick leave balance accordingly until such balance is exhausted.

[ ] YES [ ]NO

Employee Name (Please Print) ____________________ Social Security Number ____________________

Employee Signature ____________________ Date ____________________

Supervisor/ Principal Signature or Designee ____________________ Date ____________________

ANY QUESTIONS, CONTACT JOCELYN STEWART AT 225.929.8686.

Please do not write below this line