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

Dr. Andrew Davis,
Director of Risk Management

Jocelyn Stewart,
Risk Management Specialist II

Lisa Thomas,
Risk Management Specialist I

6550 Seven Oaks, Rm. #10
Baton Rouge, La 70806
Phone: 225-929-8705
Facsimile: 225-929-8707

Updated (08/2024)

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 SEND 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 No. 225-378-7884.**
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 Office of Risk Management.

6-15 SUPPLEMENTAL SICK LEAVE
Give to employee to read and sign.
Return original to the 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 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 **NOT** require a doctor visit.
Submit monthly to the EBRPSS's Office of Risk Management (W/C).

From the Office of Risk Management
Andrew Davis
Goodwood Center
6550 Seven Oaks, Rm. #10
Baton Rouge, LA 70806
Phone: 225-929-8705 Facsimile: 225-929-8707

EAST BATON ROUGE PARISH SCHOOL SYSTEM

AUTHORIZED MEDICAL FACILITIES FOR INITIAL TREATMENT OF ON THE JOB INJURES

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

1. Call the Office of Risk Management at (225) 929-8683 or 929-8686 immediately after a decision has been made to transport an injured employee to the doctor.
2. Complete the Workers' Compensation Packet and faxed to (225) 929-8707 before employee leaves the site.
3. School administrator should use discretion as to how the employee should be transported.
4. Injured employee 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** the employee health plan.

Thank you for your compliance with our Workers' Compensation procedures.

CLINIC	LOCATION	TELEPHONE
Coursey Urgent Care & Occupational Health Clinic	13702 Coursey Blvd., Bld. #10 Ste. B	755-1400
Concentra Medical Center	3235 Perkins Road	387-3030
Total Occ. Medicine Clinic	3333 Drusilla Lane	924-4460
Hours: Mon-Fri 7:00 a.m. to 11:00 p.m. Sat & Sun 9:00 a.m. – 6:30 p.m.		
Lake After Hours Clinic	3333 Drusilla Lane	924-3906
Hours: Mon-Fri 3:00 a.m. to 11:00 p.m. Sat & Sun 9:00 a.m. – 6:00 p.m.		
After Hours Emergencies and Drug Screening		
Ochsner Clinic Baton Rouge	2345 O'Neal Lane	225-761-5492
	9001 Summa Avenue	225-761-5492
****To ensure proper and effective treatment will not be delayed, please call prior to your visit.**		
Zachary Family Practice	2335 Church Street (Zachary)	225-654-3607
Emergency Rooms – IF NOT MEDICAL EMERGENCY, USE CLINICS ABOVE		
Our Lady of the Lake	Entrance on Essen Lane	765-8826
Lane Memorial	6300 Main Street, Zachary	658-4335

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 employee so that he or she may return it to their supervisor. Send billings and authorization requests to Sedgwick 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 care provider 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 charges 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 without restrictions. I also understand that I must return to work for the next regularly scheduled work shift after my release date. If I choose not to return, I will be docked up to six days sick leave after which I will be placed on leave without pay.

Employee Name (Please Print) **Social Security Number** Employee Signature and 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 potentially a Legal Document Please Type or Print Neatly)

Initial Diagnosis:
Disposition (check one)
[ ] Patient is able to return to regular 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

Signature of Physician or Authorized Representative Date

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

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 **Sedgwick Claims Management Services, Inc.**

Address **Mandeville, LA**

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)

[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.

EAST BATON ROUGE PARISH SCHOOL SYSTEM

RESTRICTED DUTY POSITIONS

ATTENTION: TREATING PHYSICIAN

The East Baton Rouge Parish School System has numerous ***Restricted Duty Positions*** available 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 advise you as to whether or not accommodations can be made, which you would approve.

OFFICE OF RISK MANAGEMENT
Jocelyn Stewart, Risk Management Specialist
Phone (225) 929-8686
Fax (225) 929-8707

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 Sedgwick, 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 Sedgwick. 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.

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 #

INDUSTRY CODE | EMPLOYER FEIN | PHONE #

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: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ 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 ( ) CANNOT BE DETERMINED ☐ AM ☐ PM | 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
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR: BY EMPLOYER
- ☐ MINOR CLINIC/HOSP
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED > 24 HOURS
- ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

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

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

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

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

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

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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 225-929-8686 immediately by telephone if medical treatment is required or if property damage is expected to exceed $500.00.