

# **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 (10/8/09)**

# 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 EBRPSS'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 **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, 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 INJURES

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

1. Call EBRPSS's Office of Risk Management (225) 929-8683 or 929-8686 immediately after a decision has been made to transport an injured employee to the doctor.
2. **Take** the injured employee to the doctor's office. **Do not allow them to drive themselves.**
3. Remind the employee and the doctor's office that the injury is to be handled through workers compensation, **NOT** employee health plan.
4. Also remind the doctor's office to screen the injured employee for drugs and alcohol.

Thank you for your compliance with our workers' compensation procedures.

| CLINIC  | LOCATION   | TELEPHONE               |
|---|--|-------------------------|
| <b>Baton Rouge General Occupational Health Clinic</b>   | 3870 Convention Street<br>(Corner of Jasmine, near BRGH) | 381-6249                |
| <b>Concentra Medical Center</b>   | 3235 Perkins Road  | 387-3030                |
| <b>Total Occ. Medicine Clinic</b>   | 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.                                  |  |                         |
| <b>Lake After Hours Clinic</b>  | 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.                                  |  |                         |
| <b>After Hours Emergencies and Drug Screening</b>   |  | <b>378-7884 (Pager)</b> |
| <b>Ochsner Clinic Baton Rouge</b>   | 2345 O'Neal Lane   | **761-5492              |
|   | 9001 Summa Avenue  | **761-5492              |
| <b>**To ensure proper and effective treatment will not be delayed, please call prior to your visit.</b> |  |                         |
| <b>Zachary Family Practice</b>  | 2335 Church Street (Zachary)                             | 654-3607                |
| <b>Emergency Rooms – IF NOT MEDICAL EMERGENCY, USE CLINICS ABOVE</b>                                    |  |                         |
| <b>Baton Rouge General</b>  | 3600 Florida (Entrance on Peach Tree)                    | 387-7600                |
| <b>Our Lady of the Lake</b>   | Entrance on Essen Lane                                   | 765-8826                |
| <b>Lane Memorial</b>  | 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 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 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 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 929-8683, or Cell at 921-3103

\_\_\_\_\_  
Signature of Physician or Authorized Representative

\_\_\_\_\_  
Date

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

# **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 consult as to whether or not accommodations can be made of which you would approve.

### **OFFICE OF RISK MANAGEMENT**

*Jessie Jackson, 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 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 JESSIE JACKSON AT (225) 929-8686 OR CELL (225) 921-3103

-----  
*Please do not write below this line.*

OFFICE OF WORKER'S COMPENSATION  
P.O. Box 94040  
Baton Rouge, LA 70804-9040  
(504)342-7565

**\*\*\*WORKER'S COMPENSATION\*\*\*  
EMPLOYER REPORT OF  
INJURY/ILLNESS**

|  |
|--|
| Employee Social Security Number          |
| Employer UI Reporting Number<br>210886   |
| Employer Federal ID Number<br>72-6000353 |

**EMPLOYEE INJURIES ONLY**  
**Please Print Neatly**

|          |      |
|----------|------|
| SALARY:  | LOC: |
| PAYROLL: | POS: |

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. **Forms for cases resulting in more than 7 days of disability or death** are to be sent to the OWCA **by the 10<sup>th</sup> day after the incident** or as requested by the OWCA.

**Purpose of Report;** (Check all that apply)

- |                                |                                |                                 |
|--------------------------------|--------------------------------|---------------------------------|
| More than 7 days of disability | Possible dispute               | Medical Only                    |
| Injury resulted in death       | Lump Sum Compromise/Settlement | <b>(no copy needed by OWCA)</b> |
| Amputation or Disfigurement    | Other                          |                                 |

|   |  |   |  |                             |  |
|---|--|---|--|-----------------------------|--|
| 1. Date of Report<br>MM/DD/YY   | 2. Date / Time of Injury<br>MM/DD/YY Time:<br>AM<br>PM | 3. Normal Starting<br>Time Day of Accident<br>AM<br>PM      | 4. If Back to Work -<br>Give Date:<br>MM/DD/YY   | 5. At Same Wage?<br>Yes No  | <b>DO NOT WRITE<br/>IN THIS<br/>COLUMN</b>   |
| 6. If Fatal Injury, Give Date of<br>Death: MM/DD/YY   | 7. Date Employer Knew of<br>Injury M/DD/YY             | 8. Date Disability<br>Began MM/DD/YY                        | 9. Last Full Day Paid<br>MM/DD/YY  | Date Received               |  |
| 10. Employee Name: First Middle Last  |  |   | 11. Male<br>Female   | 12. Employee Phone #<br>( ) | S.I.C.                                       |
| 13. Address and Zip Code  |  |   |  | 14. Parish of Injury        | State - Parish                               |
| 15. Date of Hire  | 16. Age at Illness/injury -- Date of Birth             | 17. Occupation:   |  | 18. Dept/Division Employed: | Occupation                                   |
| 19. Place of Injury-Employer's<br>Premises? Yes No  |  | 20. If No, Indicate Location-Street, City, Parish and State |  |                             | Nature                                       |
| 21. What work activity was the employee doing when the incident occurred? (Give weight, size and shape of materials or equipment involved. Tell what employee was doing with them. Indicate if correct procedures were followed.)   |  |   |  |                             | Part of Body<br>Source<br>Event<br>NCCI      |
| 22. What caused the incident to happen? (Describe fully the events that resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved, and tell how they were involved. Give full details on all factors that led or contributed to this injury or disease.) |  |   |  |                             |  |
| 23. Part of Body Injured and Nature of injury or Illness (ex. Left leg; multiple fractures)   |  |   |  |                             | 24. If Occ. Disease - Give<br>Date Diagnosed |
| 25. Physician and Address   |  |   | 26. If Hospitalized, give name & address of facility   |                             |  |
| 27. Employer's Name<br>East Baton Rouge Parish School System  |  |   | 28. Person Completing This Report - Please print   |                             |  |
| 29. Employer's Address and Zip Code<br>P.O. Box 2950 Baton Rouge, LA 70821, East Baton Rouge  |  |   | 30. Employers Telephone Number<br>(225) 929-8683   |                             |  |
| 31. Employer's Mailing Address - If Different From Above<br><b>Office of Risk Management - 6550 Seven Oaks Rm. #10 - Barton Rouge, LA 70806</b>   |  |   | 32. Nature of Business - Type of Mfg., Trade, Construction Services, etc<br>Public School System |                             |  |
| 33. Wage Information (optional) Employee was paid Daily Weekly Monthly Other.<br>The average weekly wage was \$ _____ per week.   |  |   |  |                             |  |

**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.

