Employee's Notice of Key Information Regarding Workers' Compensation

This notice and attached pamphlet have been prepared to provide you with information concerning your rights and your obligations under the Industrial Insurance Laws (Title 51) of the State of Washington. Please read them carefully.

General Information

- The Renton School District is a self-insured employer. This means the District pays your workers' compensation benefits, not the State.
- All workers in the State receive the same required minimum benefit coverage. The District pays benefits above the minimum required. The Supplemental Pension and Asbestos premium deduction is still required, but is supplemented by Renton School District. The deduction amount is determined by the Department of Labor and Industries and is subject to change annually. Based upon the amount effective January 1, 2009, the total employee's deduction is just over 4 cents per hour worked and is matched by Renton School District.
- The District contracts with a service company, Tristar, which administers all claims.
- The Self-Insurance Office of the Department of Labor and Industries makes all actions and final decisions on claims involving time loss.

Your Rights and Responsibilities

- You must immediately report your injury/disease to your supervisor.
- You have up to one year from the date of injury to actually file a claim.
- To file a claim:
  Complete a "Self Insurer Accident Report (SIF-2)" available from your supervisor and submit immediately to Human Resources.
  - Take a copy of the "Provider's Initial Report" with you to a practitioner of your choice.
  - Be treated by a practitioner for your injury/disease.
  - Any change in your treating practitioner must be pre-approved by Amy Stone.
  - You should keep the District advised of your progress. Report anticipated length of absence.
  - Your physician must provide medical progress reports.
  - If your claim is rejected because your injury/disease is not work-related, you may be required to repay the conditional payments you have received.

Medical Costs

- Your medical service and related benefit expenses must be the result of a qualifying work-related injury/disease.
- The District will pay for medical services and related benefits as determined by law and authorized by the Department of Labor and Industries until the claim is closed.
- You are not to be charged for any authorized treatment.

Time Loss compensation

- To be eligible for time loss, you must be under the care of an authorized practitioner who certifies that you are temporarily disabled and unable to return to work due to this injury/disease.
- The amount you receive is dependent upon your marital status and number of dependents. The amount available ranges from 60-75% of your base wages.
- RESP & Prof Tech EMPLOYEES ONLY: Beginning the day of injury, the District will allocate 40% of a day's sick/vacation leave for every regularly scheduled work day you receive workers' compensation time loss payments until such accumulated sick/vacation leave is exhausted, except that calendared holidays will be paid as holiday pay. You may choose, in writing, to use sick leave and, instead, receive workers' compensation time loss payments only in compliance with Industrial Insurance Laws of the State of Washington.

- ALL OTHER EMPLOYEES: Beginning on the day of injury, the District will pay full salary and benefits during the first 60 calendar days for eligible time loss. For time loss, which extends beyond 60 calendar days from the date of injury, you may make a one-time election regarding use of your accumulated sick leave beginning with the 61st day.

You will receive workers' compensation only in compliance with Industrial Insurance Laws of the State of Washington and your collective bargaining agreement.

- Time loss benefits from the District will continue until:
  - You return to regular duty, with a doctor's release;
  - You are released by your doctor for light duty and light duty is assigned by the District;
  - You refuse to accept a light duty assignment, or
  - You refuse to follow laws governing treatment of on-the-job injuries.

The method by which Renton School District determines Time Loss Certification includes, but is not limited to:

- Certificate of Disability
- Medical Reports
- Release for Work Slip
- Self Insurer Accident Report (SIF-2)
- Phone Calls

Our Self-Insured Program Administrators, Tristar, will obtain this information.

Claim Closure

- Your claim will be submitted for closure when no further curative treatment is indicated.
- Permanent Partial Disability Awards are determined by the Department of Labor and Industries and may be awarded in the case of permanent percent of loss in function of a body part due to industrial injury or disease.

Reconsideration's and Appeals

- The Department of Labor and Industries, not the Renton School District issues all orders on Industrial Insurance claims.
- If you do not agree with an order on your claim, you may file a protest in writing within 60 days of receipt of the order to:

Administrator, Self-Insurance Section
Department of Labor and Industries
PO Box 44892
Olympia, WA 98504-4892

For any questions or concerns regarding an injury claim, contact the District's claims administrator listed below. Remember, keeping us informed will help to eliminate delays and will help to ensure prompt handling of your claim.

Tristar
Amy Stone
P.O. Box 2805
Clinton, IA. 52733-2805
971-925-1300 EXT 1920

EMPLOYEE:

You have received this folder as a result of notifying your supervisor that you have been involved in an on-the-job injury. We want to do everything possible to assist you in your recovery. Please follow the steps outlined in this folder so we can do everything possible to provide a safe work site as well as:

- Preserve your wages to the extent possible,
- Assure continuation of your health insurance coverage, and,
- Contain the cost of both yours and RSD workers compensation costs. (Note the L&I deduction on your paycheck).

If you will need medical care related to your workers' compensation claim you must verify that your doctor or health-care provider has enrolled in L&I's Medical Provider Network.

Why is it important to know if your provider is in the network?
Only network providers can deliver ongoing medical treatment for your work-related injury or condition.

How to verify if Provider is in-Network:

1. Check your provider's network status at www.findadoc.lni.wa.gov If your provider is in the network, no further action is needed.
2. If your provider has not applied to the network, encourage them to do so. If they do not apply, you must transfer to a network provider.
3. If your provider does not plan to apply, transfer to a network provider.
    a. Find network providers in your area using www.findadoc.lni.wa.gov
    b. Contact new providers to make sure they will accept you as a patient and make an appointment.
    c. Once you have an appointment, request a transfer of care by contacting your employer or third-party administrator.

Read the enclosure for more information about the network.

- What is L&I's medical provider network?
- Using network providers for all or your care.
- Which provider types must join the network?

After verification follow these steps:

1. Take this folder to your doctor on your first visit.

2. Have your doctor complete the "Provider's Initial Report" and make any comments he/she feels are necessary for you to safely return to work. Remind your doctor that Renton School District has a light duty program and should be able to tailor to your needs.

3. **Return this folder to your supervisor on the same day you see your doctor and complete the "On-The-Job-Injury" report.** If you are unable to return that day, notify your supervisor by phone **immediately**, and then follow the same procedures as if you were ill.

4. **DO NOT PERFORM WORK BEYOND YOUR MEDICAL RESTRICTIONS**.

5. If you are released to light duty, please contact Human Resources immediately to determine if light duty work is available.

6. If you have any questions you may contact the Renton School District Workers Compensation and Leave Coordinator:

   Renton School District Administration Office
   Ryan Rudolph
   300 SW 7th Street
   Renton WA 98057
   425-204-2298
   ryan.rudolph@rentonschools.us

Complete the "Self Insurer Accident Report (SIF-2) and return within 24-hours of your accident. Do not leave this form with your doctor.

Employee On-the-Job-Injury Process

The following are steps to take when an employee has been injured and needs to file an On-the-Job-Injury report (Workers' Compensation Claim).

OFFICE MANAGER PLEASE DO THE FOLLOWING:

1. Give the employee a Workers' Compensation packet. (Red folder)
2. After employee has completed steps 1 through 3 (if applicable), outlined below, have the employee's supervisor complete, sign and date the Employer Section of the SIF-2 form and complete, sign and date a Supervisor On-The-Job Injury report. You do not need to complete any wage or hour information.
3. Mail the completed, signed SIF-2 form, along with the Employee On-The-Job-Injury report and any other claim related paperwork directly to Human Resources.

EMPLOYEE PLEASE DO THE FOLLOWING:

1. The employee completes the Self Insurer Accident Report (SIF-2), the Employee On-The-Job-Injury report and has their supervisor complete the Supervisor On-The-Job-Injury report. All forms must be signed and dated by the employee and supervisor and the location where the injury occurred is noted at the bottom of the SIF-2 form.
2. If a Doctor visit is required, have the doctor complete the "Provider's Initial Report" (located in the Workers' Compensation packet). The doctor should make any comments necessary for the employee to safely return to work. Remind the doctor that Renton School District has a light duty program and should be able to tailor work to the employee's needs.
3. The completed, original "Provider's Initial Report" form is turned in with all claim related paperwork, a copy should be kept by the employee and the physician.

If an Employee is not filing a claim, then an Employee On-The-Job-Injury report and Supervisor On-The-Job-Injury report must be completed, signed, dated and returned to HR.

If you have any questions, please contact the District's Workers Compensation and Leave Coordinator:

Ryan Rudolph, CDMS, CEAS III
Renton School District Administration Office
300 SW 7th Street
Renton WA 98057
425-204-2298
ryan.rudolph@rentonschools.us

Rev 01/11/2017

ON-THE-JOB-INJURY REPORT

EMPLOYEE'S REPORT (This report is to be completed with your supervisor immediately following an accident. Original must be returned to Human Resources.)

Employee _____ Work Location_____ Work Phone _____

Position _____Shift Hours_____ Supervisor _____

Date of Accident_____Time of Accident _____ Place of Accident _____

Describe the accident (Give complete details and what you were doing when injury occurred) _____

_____

_____

Where were you taken after the accident_____ By whom _____

Description of injury _____

_____

Projected return to work date _____Total work days lost_____

Attending Physician _____ Address _____ Phone_____

Nature of treatment _____

Have you filed for Workers' Compensation? _____ (If yes, take the "Provider's Initial Report" to the attending physician and file the "Self-Insurer Accident Report (SIF-2)" immediately.)

Witness(es):

Name _____ Work Location_____ Work Phone _____

Name _____ Work Location_____ Work Phone _____

My signature authorizes Renton School District to contact my physician concerning injury resulting from this reported accident. Any time missed from work requires a "Return to Work" authorization from my physician.

Employee Signature_____ Date _____

ON-THE-JOB-INJURY REPORT

SUPERVISOR'S REPORT (To be completed by Supervisor or Designee. Original must be returned to Human Resources.)

Employee Injured _____ Work Location_____ Work Phone _____

Position _____Shift Hours_____ Time of Accident_____

Date of Accident_____ Place of Accident _____

Describe the Accident _____

_____

_____

Where was the employee taken after the Accident _____ By Whom _____

Description of Injury _____

_____

Projected length of Disability _____Anticipated Work Days Lost _____

Witness(es):

Name _____ Work Location_____ Work Phone _____

Name _____ Work Location_____ Work Phone _____

Did negligence cause this accident? _____Recommendations for improved safety

_____

_____

Supervisor's Comments _____

Supervisor's Signature _____ Date _____

DOCTOR:

Renton School District values the health and welfare of our employees a great deal. We realize that inability to work creates an economic hardship for our employee(s) as well as our company. We have found that the longer an employee is off work, the more difficult the return-to-work process becomes.

For this reason, we are willing to consider significant modifications of the work site, or even a temporary change of duties whenever possible, to assist our employees return to work as quickly and safely as possible.

We can accommodate most regular duty jobs to fit an employee's ability if you will provide us with specific restrictions. Please complete the "Provider's Initial Report" form located in this packet. In addition, we are able to offer alternative work for at least a temporary period.

We ask all employees who are unable to work to maintain a weekly schedule with their attending doctor until they are able to return to work. We appreciate your assistance in this request.

If you need further assistance, you may contact the District's third-party administrator:

Tristar
Attn: Amy Stone
P.O. Box 2805
Clinton, IA 52733-2805
971-925-1300 ext 1920

(Select one) Language Preference ☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other _____

MAIL TO SELF-INSURED COMPANY

PROVIDER'S INITIAL REPORT

A Provider's Initial Report (PIR) completed by the provider and the worker, establishes a claim. When the completed PIR is received by the employer, they must assign a claim number and adjudicate the claim.

1.CLAIM NUMBER

1. NAME OF SELF-INSURED EMPLOYER
Renton School District #403

ADDRESS
300 S.W. 7th Street

CITY: Renton | STATE: WA | ZIP: 98057

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE
Amy Stone

ADDRESS
P.O. Box 2805

CITY: Clinton | STATE: IA | ZIP: 52733-2805

EMPLOYER'S TELEPHONE NUMBER: 425-204-2298

EMPLOYER'S SERVICE REP PHONE: 971-925-1300

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST

3. WORKER'S TELEPHONE NO.

4. MAILING ADDRESS

5. SOCIAL SECURITY NUMBER

6. CITY | STATE | ZIP

7. DATE OF BIRTH

8. INJURY DATE | 9. TIME | ☐ AM ☐ PM

10. Have you missed work due to your injury? If so, what dates were you off?
From: | To:

11. SEX

12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS

12B. NUMBER OF DEPENDENTS

13. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider – **START HERE**

3. This exam date

4. Date patient first seen by you for this injury/condition

a. ICD Dx CODES	b. Diagnosis – specify Right/Left

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, Specify

6. Referred for Diagnostic Studies
☐ No ☐ Yes, Specify

7. Treatment Recommendations

8. Did you refer the patient to an L&I medical network provider for follow-up?
☐ YES ☐ NO Referred to:

Address

Phone

14. MEDICAL RELEASE AUTHORIZATION: PURSUANT TO RCW 51.36.060, I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY RELEVANT MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.

Worker's Signature Date

15. I have read the statement of Responsibility and the Legal Notice on the next page of this form.

Worker's Signature Date

9. a. Has the worker ever been treated for the same or similar condition?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

b. Is there any pre-existing impairment of the injured area?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

c. Are there any conditions that will prevent or retard recovery?
Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

d. Was the diagnosed condition caused by this work injury or exposure on a more probable than not basis? (check one)
Yes ☐ Probably (51% or more) ☐
No ☐ Possibly (Less than 50%) ☐

10. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?

Lifting | Bending

Standing | Sitting

Other

d. If not released, how many days off work due to the work injury?

Licensed Healthcare Provider must sign before report is accepted
11. Signature

12. Phone | 13. Date

14. Attending Healthcare Provider Name

15. Address

City | State | ZIP

16. L&I Provider Number or NPI | 17. IRS Account #

DO NOT SEND THIS FORM TO

LABOR & INDUSTRIES

WEB ADDRESS TO CHECK FOR UPDATES OF FORM:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467

NOTE: Beginning Jan. 1, 2013, injured workers will need to get ongoing care from a medical provider who is part of the L&I Medical Provider Network. They may see a non-network provider for the initial visit, but for additional or ongoing care, they will need to transfer to a network provider.

MAIL TO SELF-INSURED COMPANY

1. If the worker brings this form to your office, this box may be pre-printed. If you initiate the form in your office, obtain information from the worker.

2. Have the worker complete this box or obtain information from the worker.

ATTENDING HEALTH CARE PROVIDER INFORMATION

NOTICE: FAILURE TO FILE THIS REPORT WITHIN 5 DAYS FROM THE DATE OF TREATMENT MAY RESULT IN A PENALTY OF $250 IN ACCORDANCE WITH RCW 51.48.060.

3. This exam date.

4. Date you first treated patient for this injury/condition.
a) Insert ICD Dx coding which corresponds to narrative diagnosis in Box 3b.

b) Please list all diagnoses of conditions present which are result of incident or exposure. Also specify which side of body (right/left).

5. Indicate "Yes" or "No". If "Yes", list objective findings which support diagnosis. Do not restate diagnosis.

6. Indicate "Yes" or "No". If "Yes", specify study and complete findings if known.

7. Indicate treatment recommendations.

8. Specify name, address and phone number of health care provider to whom referred. Treatment beyond the initial visit must be done by providers enrolled in Washington's workers compensation medical provider network. (This applies to workers of Self-Insured and State Fund employers.) Information to enroll in the network is available at JointheNetwork@Lni.wa.gov. If you choose not to enroll and your patient needs additional treatment, refer him or her to a network provider. The provider directory is available at www.Lni.wa.gov.

9. Indicate "Yes" or "No" and provide the additional information requested.

10. Indicate "Yes" or "No" and provide the additional information requested.

11. Signature of health care provider providing treatment and completing form.

12. Health care provider's phone number.

13. Date health care provider signs report

14. Print or type your name as it appears on your Department of Labor and Industries payee account.

15. Indicate your full mailing address.

16. Indicate your Department of Labor and Industries issued provider number or NPI.

17. Provide your Internal Revenue Service reporting account number.

PATIENT INFORMATION

1. Leave blank.

2. Name of injured worker.

3. Worker's phone number.

4. Worker's mailing address or street address.

5. Worker's social security number.

6. City, state and ZIP code of worker's address.

7. Date worker was born.

8. Date accident occurred.

9. Time accident occurred.

10. Dates the worker missed work due to this injury.

11. Indicate -- M = Male F = Female

12A. Marital/Registered Domestic Partnership Status, e.g., M = Married, S = Single, D = Divorced, DP = Registered Domestic Partnership.

12B. Dependents -Number of dependents under age 18 (does not include spouse/domestic partner).

13. Brief description of accident or exposure by worker.

14. Medical Release Authorization. Worker's signature authorizes the release of relevant medical information.

15. Statement of Responsibility - I have reported or will report this incident or exposure to my employer. If my claim is denied, I understand that I will be responsible for the care provided to me.

16. LEGAL NOTICE --RCW 51.48.020 (2) PROVIDES: ANY PERSON CLAIMING BENEFITS UNDER THIS TITLE WHO KNOWINGLY GIVES FALSE INFORMATION REQUIRED IN ANY CLAIM OR APPLICATION UNDER THIS TITLE SHALL BE GUILTY OF A FELONY, OR A GROSS MISDEMEANOR.

Renton School District #403 is self-insured.
Our third party administrator is:

Tristar
Attn: Amy Stone
P.O. Box 2805
Clinton, IA 52733-2805
971-925-1300 ext 1920