Troup County School System

Troup County School System
Workers' Compensation Drug Testing Authorization

Please select a physician from the list below

☐ **UrgenCare Clinic 2169 West Point Road LaGrange, GA 30240 706-668-5140 Contact@urgencareclinic.com**

☐ **Piedmont Urgent Care 1524 Lafayette Parkway LaGrange, GA 30241 706-530-2151 07LGR@wellstreet.com**

DATE:_____ TIME:_____AM_____PM_____

PHOTO IDENTIFICATION IS REQUIRED

The following employee is authorized by the Troup County School System to undergo the procedure checked below following an on-the-job accident/injury.

EMPLOYEE NAME:_____

_____10 Panel Drug Screen _____Alcohol Testing

SERVICES AUTHORIZED BY:

School District Representative:_____

Title:_____ Phone:_____

I understand that I must ***IMMEDIATELY*** report to one of the above listed locations for drug/alcohol testing or risk losing any Workers' Compensation benefits.

Employee Signature:_____ Date:_____

(Rev. 12/23)

Troup County School System

Employer Authorization Form

Please indicate which clinic you will be using for employer services. _____ *(clinic)*

Company Details	Date: / /	Employee Details:
Company Name: _____		***Patient Name:*** _____
Authorizing Contact: _____		***DOB:*** _____
Phone #: _____		**Employee must present photo ID at time of visit unless accompanied by escort.*
Email: _____		

Authorization Category

- O ***Pre-Employment***
- O ***Work Comp***
- O ***Post Accident***
- O ***Random***
- O ***Annual/Periodic***
- O ***Follow-up***
- O ***Reasonable Suspicion***

_____

Work Comp

- O **Treatment Only**
- O **Drug Screen - Mark Below**

Date/Time of Injury _____

Injured Body Part _____

Drug Screen Selections

- O ***Breath Alcohol - NON-DOT***
- O ***Rapid 10 Panel***
- O ***Hair Follicle***

Accident Description

Job Title_____ ***Location***_____

Description of accident and body part injured (**Be Specific**) _____

_____

_____

_____

_____

By signing this form, I am authorizing treatment and appropriate injury management by our medical staff for the above employee. Authorization includes physician intervention, diagnostic testing, physical therapy and medications if indicated by the treating physician along with all non-work related injury care.

For work related injuries, I understand that is my ultimate responsibility to notify my insurance carrier of the employee's injury in order to establish a claim under workers' compensation and assure procedures and payment per Georgia's Workers' Compensation Act. If this claim is determined to be a non-work related injury/illness, I also understand that I am responsible for ALL BILLS generated by this claim until I inform Piedmont Urgent Care in writing of when the claim is being controverted.

For all billing. Payment is to be made within 30 days of receipt of the bill. If payment is not made, then a 10% penalty will be added at 30 and 60 days.

Authorized by: _____ **Email:** _____

Signature: _____ **Date:** _____

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested.

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

_____

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(l) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

Troup County School System
Workers' Compensation Benefits

NAME OF EMPLOYEE _____ DATE_____

SCHOOL OR DEPARTMENT_____

DATE OF ACCIDENT_____

Check one of the options below: (Although you may not miss time from work, one of the options **must** be chosen)

_____1. Sick leave for the duration of the illness/accident. (You will receive sick pay only if you have days available). Workers' Compensation will begin after sick leave has been exhausted for a compensable incident.

_____2. Sick leave for the first 7 calendar days (5 business days), then Workers' Compensation beginning on the 8th calendar day (6th business day).

_____3. Leave without pay until Workers' Compensation begins payment. (Workers' Compensation begins Payment on the 8th calendar day or 6th business day).

**NOTE

Workers' Compensation begins payment on the 8th day of illness or accident. If you are out for 21 consecutive days, payment will be retroactive to the first day of disability. Workers' Compensation will be paid at 66 2/3rd% of your average weekly wage, not to exceed $500.00 per week. You cannot receive both Workers' Compensation benefits and Salary Continuation at the same time.

If you are out and not receiving a check from the school system, this can affect your service credits with the retirement system. If so, please write a letter to the retirement system requesting reinstatement of service credits while you were out of work due to a work related injury. This must be done within six (6) months of your return to work from the injury.

I have been informed concerning my options and understand how that option will affect my pay status.

Employee's Signature_____ Date _____

Supervisor's Signature_____ Date_____

Revised: 01/02/2024

Troup County School System

TROUP COUNTY SCHOOL SYSTEM
EMPLOYEE'S STATEMENT OF WORK-RELATED INJURY

Employee should complete this form immediately after the incident. ALL questions must be answered.

Employee Name_____SS#_____

Job Title_____School/Department_____

Normal Work Hours_____Phone Number ( )_____

Address_____
Street City State Zip

Did you have an injury/accident while working for the Troup County School System? Yes_____ No _____

Location of Injury/Illness: On Premises_____Off Premises_____Approved Route_____

Place_____Address_____
Classroom, Cafeteria, Playground, Parking Lot, etc.

Name all body parts injured. (right hand, left foot, etc)_____

_____

What type of injury? (burn, sprain, broken bone, etc.)_____

_____

Describe event in detail._____

_____

_____

_____

_____

Were there any contributing factors to accident? (Conditions of surroundings, items on floor), personal actions (carrying items), actions by others._____

_____

_____

What could be done to prevent a similar accident in the future?_____

_____

_____

_____

What date did the injury occur? _____ Was the injury reported the day of the accident? Yes_____ No_____

If no, please explain. _____

_____

Who was injury reported to?_____Date reported_____

Who saw the accident happen?_____

Did you leave work as a result of the injury? Yes_____ No_____ Time left work_____

Did you seek medical treatment? Yes____ No____

Are you employed with any employer other than Troup County School System?_____

If so, name of employer and position held_____

Additional information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My signature below indicates that I have completed this accident statement in my own handwriting, or if unable to do so, the responses filled out by my employer have been reviewed by me, and everything contained in this report is accurate and true.

Employee Signature_____Date_____

Supervisor's Incident Investigation Report

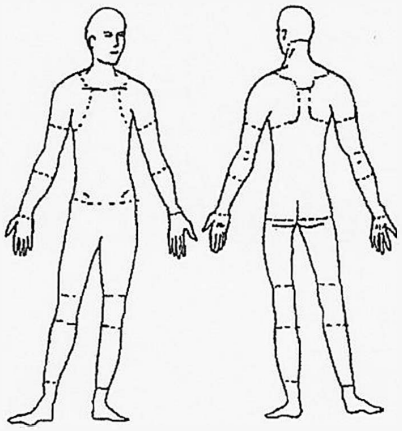
Instructions: Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

This is a report of a: ❑ Death ❑ Lost Time ❑ ER/Clinic Treatment ❑ First Aid Only ❑ Near Miss	
Date of incident:	This report is made by: ❑ Supervisor ❑ Team ❑ Other_____

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: ❑ Male ❑ Female	Age:
Department:	Job title at time of incident:	

Part of body affected: (shade all that apply)



Nature of injury: (most serious one)
- ❑ Abrasion, scrapes
- ❑ Amputation
- ❑ Broken bone
- ❑ Bruise
- ❑ Burn (heat)
- ❑ Burn (chemical)
- ❑ Concussion (to the head)
- ❑ Crushing Injury
- ❑ Cut, laceration, puncture
- ❑ Hernia
- ❑ Illness
- ❑ Sprain, strain
- ❑ Damage to a body system:
- ❑ Other _____

This employee works:
- ❑ Regular full time
- ❑ Regular part time
- ❑ Relief
- ❑ Temporary

Length of time doing this job:

If applicable, name of other employer:

Step 2: Describe the incident

Exact location of the incident:	Exact time:

What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities ❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____

Names of witnesses (if any):

Number of attachments:	Written witness statements:	Photographs:	Maps / drawings:

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.

Description continued on attached sheets: ❑

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)
- ❑ Inadequate guard
- ❑ Unguarded hazard
- ❑ Safety device is defective
- ❑ Tool or equipment defective
- ❑ Workstation layout is hazardous
- ❑ Unsafe lighting
- ❑ Unsafe ventilation
- ❑ Lack of needed personal protective equipment
- ❑ Lack of appropriate equipment / tools
- ❑ Unsafe clothing
- ❑ No training or insufficient training
- ❑ Other: _____

Unsafe acts by people: (Check all that apply)
- ❑ Operating without permission
- ❑ Operating at unsafe speed
- ❑ Servicing equipment that has power to it
- ❑ Making a safety device inoperative
- ❑ Using defective equipment
- ❑ Using equipment in an unapproved way
- ❑ Unsafe lifting
- ❑ Taking an unsafe position or posture
- ❑ Distraction, teasing, horseplay
- ❑ Failure to wear personal protective equipment
- ❑ Failure to use the available equipment / tools
- ❑ Other: _____

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a workplace culture, norm, or expectation that may have encouraged the unsafe conditions or acts? ❑ Yes ❑ No

If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ❑ Yes ❑ No

Have there been similar incidents or near misses prior to this one? ❑ Yes ❑ No

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

❑ Stop this activity ❑ Guard the hazard ❑ Train the employee(s) ❑ Train the supervisor(s)

❑ Redesign task steps ❑ Redesign work station ❑ Write a new policy/rule ❑ Enforce existing policy

❑ Routinely inspect for the hazard ❑ Personal Protective Equipment ❑ Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: ❑

Step 5: Who completed and reviewed this form? (Please Print)

Written by: Department:	Title: Date:
Names of investigation team members:	
Reviewed by:	Title: Date:

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

PANEL OF PHYSICIANS

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

The insurance company providing coverage for this business under the Workers' Compensation Law is:

Johns Eastern Company
Insurer Name

P.O. Box 110279 Lakewood Ranch, FL 34211 (877) 879-9296
address phone

	State Board of Workers' Compensation 270 Peachtree St., NW Atlanta, GA 30303-1299 404-656-3818 1-800-533-0682 www.sbwc.georgia.gov	Piedmont Urgent Care 1524 Lafayette Parkway LaGrange, GA 30241 706-530-2151
Emory Southern Orthopedics 1805 Vernon Rd. LaGrange, GA 30240 706-884-2691 Dr. Robert Comerford, M.D.	Hughston Clinic 107 Calumet Center Rd. LaGrange, GA 30240 706-884-3274 Dr. Erik Westerland, M.D. (Spine) Dr. David Rehak, M.D (Hand/Wrist/Elbow) Dr. Champ Baker, M.D. (Upper & Lower Extremity) Dr. Matthew Steward, M.D.(Foot/Ankle)	Georgia Bone & Joint 1755 Highway 34 East, Ste. 2200 Newnan, GA 30265 770-502-2175 Dr. Chad Kessler, M.D. (Spine) Dr. Michael Cushing, MD.(Upper & Lower Extremity) Dr. Michael Gruber, M.D. (Hand/Elbow/Extremity)
Wellstar General Surgery 1600 Vernon Road, Ste. A LaGrange, GA 30240 706-880-7321	UrgenCare Clinic 2169 West Point Road LaGrange, GA 30240 706-668-5140	West Georgia Vision Center 407 S. Greenwood St. LaGrange, GA 30240 706-882-0616

(Additional doctors may be added on a separate sheet)

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A § 34-9-18 and § 34-9-19

Rev 01/02/2024

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.

2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.

3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.

4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.

5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.

6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $533.33 per week, not to exceed 350 weeks.

7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $533.33 per week for no longer than 350 weeks.

8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $800 per week. A widowed spouse with no children will be paid a maximum of $320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.

2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.

3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.

5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.

6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.

7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.

8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.

10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.

11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.

12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.