Employee Accident/Incident Packet

Once completed, please fax to:

Benefits Department

770-266-4448

Dear Employee:

This package is designed to inform you of your rights and responsibilities under the Workers' Compensation Laws. This package contains:

- The Employee Accident/Incident Report
- The Employee Election of Worker's Compensation Benefits Form
- State of Georgia Board of Workers' Compensation Form WC 207
- Notice to Provider/Return to Work Notice
- Employee Guidelines for Workers' Compensation Accidents
- The Bill of Rights for the Injured Worker
- The Official Notice/Panel of Physicians

Please sign this form acknowledging receipt of this package and return this letter along with the Employee Accident/Incident Report, the Employee Election of Worker's Compensation Benefits form and form WC 207 to the Benefits Office within three days of the reported accident/incident.

_____

Print Employee's Name

_____ ___/___/___

Employee's Signature **Date**

BENEFITS DEPARTMENT
PHONE: (770) 266-4444 or (770) 266-4442
FAX: (770) 266-4448

Walton County School District
EMPLOYEE ACCIDENT/INCIDENT REPORT

Accident ☐ Incident ☐

INJURED PERSON SHOULD COMPLETE THIS FORM IN ITS ENTIRETY WITHIN 72 HOURS OF THE ACCIDENT/INCIDENT OCCURRENCE AND SEND TO:

Benefits Office - PHONE (770) 266-4444 or (770) 266-4442 FAX: (770) 266-4448

EMPLOYEE IDENTIFICATION:

Actual Date/Time of Accident/Incident:	Date/Time Accident/Incident was reported:
Employee's Name:	
Employee's Address:	
Home Phone:	Cell Phone:
School Location/Department	Job Title
Employee #	Birth Date:

ACCIDENT/INCIDENT INFORMATION:

Where did the accident occur?

Indoors - Please provide building/room number or area such as stairs, hallway, etc.
Outdoors - Describe area.

Were you performing regular job duties at the time of the accident/incident? Yes ☐ No☐

Is this type of work performed on a regular basis? Yes ☐ No☐

Please describe fully the event which resulted in the accident/incident. Detail what happened and how it happened. Name any object, persons, or substances involved and how they were involved. Provide full details of all factors which led to the accident/incident. Use back of page if necessary.

Describe the position you were in when you were injured. (Example: sitting, standing,, squatting,, bending,)

What, if anything, could have been done to prevent this accident/incident?

Were there any witnesses? Yes ☐ No☐ If yes, please provide name and phone number of all witnesses:

Accident/Incident was reported to:

Did the accident/incident involve a slip, trip or fall? Yes ☐ No☐

Walton County School District

EMPLOYEE ACCIDENT/INCIDENT REPORT

Accident ☐ Incident ☐

INJURY INFORMATION:

Type of injury (cut, swelling, pain, exposure, bruise, burn, etc.)

If **injury occurred, please check the portion of the body that was injured:**

	Left☐	Right☐		
☐ Hand	☐ Finger (s)	☐Ann	☐ Elbow	☐ Wrist
☐ Shoulder	☐Neck	☐ Face	☐ Teeth	☐ Eye(s)
☐ Foot	☐ Toe(s)	☐Leg	☐Knee	☐ Ankle
☐ Head	☐ Ear(s)	☐Nose	☐ Throat	☐ Lungs
☐ Abdomen	☐ Groin	☐ Lower Back	☐ Mid Back	☐ Upper Back

If injury occurred, is the injury an aggravation of an old/prior injury? Yes ☐ No☐
If yes, please explain:

If lifting was involved, please indicate approximate weight of material being lifted and how high it was lifted:

If injury occurred, did it appear immediately? Yes ☐ No☐
If no, when did you realize you were injured? _____

Do you need to be treated by a physician?*

Yes ☐ No☐ If yes, physician's name:

*** Please refer to the Panel of Physicians**

Did you miss work? Yes ☐ No☐ If yes, please list days away from work.

Additional remarks:

Employee Signature/Authorization

I certify the above is an accurate description of the accident and the injury I sustained while working for the Walton County School District. I understand that if I need medical attention for this injury, I must choose a physician from the posted panel. Should my injury/illness prove to be non-related to my employment, I will be responsible for any medical bills incurred.

Employee Name (Print) Employee Signature Date

Supervisor Signature/Authorization -

As supervisor of the above named individual, I am aware of this on the job injury.

Supervisor's Name (Print) Supervisor's Signature Date

WALTON COUNTY SCHOOL DISTRICT
EMPLOYEE ELECTION OF WORKERS' COMPENSATION BENEFITS

Name of Employee: _____ **Work Location:** _____

Social Security: _____ **Date of injury:** __ /__ /__

Under the provisions of the Georgia Workers' Compensation Act, an employee who is disabled in a work-related accident is entitled to weekly Workers' Compensation benefits equal to two-thirds (2/3) of the employee's average weekly wage, up to a current maximum of **$725.00** per week. These benefits commence on the eighth (8) calendar day of disability. Compensation for the seven (7) day waiting period (five (5) working days) becomes payable only if the employee is disabled from work for twenty- one (21) consecutive days.

Instead of receiving weekly indemnity benefits, an employee may elect to receive full salary in lieu of Workers' Compensation benefits if the employee has sufficient Sick Leave to cover such an absence.

According to our records, you have accumulated _____day(s) Sick Leave as of _____

Please indicate in the appropriate space below which option you wish to choose:

_____ I. Sick Leave for the duration of the work-related injury. If all Sick Leave is used before being returned to work, Workers' Compensation benefits will pay for the remaining period of disability.

_____ 2. Sick Leave for the first seven (7) calendar days, then Workers' Compensation benefits beginning on the eighth (8) calendar day of disability.

_____ 3. Leave without pay until Workers' Compensation benefits begin on the eighth (8) calendar day.

_____ 4. Summer pay for the duration of summer break for my work-related injury. If the new school year begins before being returned to work, Workers' Compensation benefits will pay for the remaining period of disability.

NOTE: In electing to use Sick Leave in lieu of Workers' Compensation benefits, the employee agrees to return any Workers' Compensation monies that are received that cover the same period of time that has already been paid by Sick Leave. If still employed by the Walton County School District, the employee's signature herewith authorizes the Walton County School District to withhold this amount from future earnings.

I understand that my election is irrevocable.

_____ ____/____/____

Signature of Employee **Date**

_____ ____/____/____

Employer Representative **Date**

"In Pursuit of Excellence"

Notice to Provider

(To be presented to doctor, hospital, or clinic by injured party when reporting for treatment)

_____ has reported that he/she was injured on _____

(Print Employee Name) (Date of Injury)

Please forward all reports and bills to the following address:

Brentwood Services
P.O. BOX 1125
Brentwood, TN 37024-1125
Fax 615-760-2148

_____ _____

School Location/ Employee Signature Phone

_____ _____

Principal/Supervisor/District approved Signature (authorizing treatment) Date

NOTE: This is not an acceptance of liability.

Return to Work Notice

(To be completed by Doctor after examining employee)

Name of Doctor's Office/Clinic_____

Location_____ Phone_____

Diagnosis_____

☐ Employee **IS** able to return to regular duties at this time.

☐ Employee **IS** able to return to light duties at this time, **list limitations:**_____

_____

☐ Employee **IS NOT** able to return to work at this time because: _____

☐ Employee was prescribed medication. **List Medications prescribed:** _____

_____

Will prescribed medication limit employee's ability to perform job duties? YES ☐ NO ☐

_____ _____

Request Referral to: (if applicable) Follow-up appointment date

_____ _____

Signature (Doctor) Date

ATTN PHYSICIANS OFFICE: Please fax completed form to WCSD Benefits Office at 770-266-4448 and Brentwood Services at 615-760-2148

EMPLOYEE GUIDELINES FOR WORKERS' COMPENSATION ACCIDENT
EFFECTIVE: 7/1/2020

The Walton County School District operates under the Georgia Workers' Compensation and is self-insured. The following guidelines have been designated to help you avoid problems should a work-related injury occur.

- Report the accident immediately to your supervisor no matter how insignificant it may seem.
- Complete an employee accident report and benefit election form within (3) days of the accident and return it to your principal/supervisor. Delay in notification could result in denial of payment for any medical services rendered.
- If the injury necessitates medical attention, select a doctor from the "Panel of Physicians" and notify the school office. The "Panel of Physicians" and a "Bill of Rights for the Injured Worker" are posted at each facility of the Walton County Board of Education.
- In case of an emergency, you may seek medical treatment from an emergency facility until the immediate emergency is over. However, a doctor from the "Panel of Physicians" must provide any additional medical treatment you receive.
- If you miss work as a result of a compensable injury, you may be entitled to receive pay for lost time. This is dictated by the benefit election form you completed with the accident report.
- If you have any questions regarding Workers Compensation benefits, the "Panel of Physicians", medical bills, authorizations, etc., contact Kelly White at Brentwood Services at 615-263-1738.

The employee **completes** the following:

- Employee Accident/Incident Report
- Employee Election of Worker's Compensation Benefits
- Form WC207

The employee **keeps** the following:

- Employee Guidelines for Workers' Compensation Accidents
- The Bill of Rights for the Injured Worker
- The Official Notice/Panel of Physicians

This form should be given to panel physician if medical appointment is made:

- Notice to Provider/Return to Work Notice

BENEFITS DEPARTMENT
PHONE: (770) 266-4444 or (770) 266-4442
FAX: (770) 266-4448

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).

(This notice must be posted in a conspicuous place readily accessible to the employees 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:

Insurer Name: BRENTWOOD SERVICES ADMINISTRATORS Phone: 615-263-1738

Address: PO BOX 1949 BRENTWOOD, TN 37024

Insurer Email: CLAIMS.CLAIMS@BWOOD.COM

Instructions to injured worker: Review the following physician's contact information and select the provider with whom you would like to receive medical treatment.

Physician's Contact Information: Name, Address, Phone, and website listed below:

1. PIEDMONT URGENT CARE BY WELLSTREET
   4763 ATLANTA HWY STE 420 LOGANVILLE, GA 30052 (470) 395-6793 (ALSO LOCATED IN SNELLVILLE AND COVINGTON)
2. PEACHTREE IMMEDIATE CARE
   4072 ATLANTA HWY LOGANVILLE, GA 30052 (678) 905-0236 (ALSO LOCATED IN MONROE)
3. PIEDMONT PHYSICIANS OF MONROE
   2161 W. SPRING STREET STE A MONROE, GA 30655 (770) 267-8467
4. ATHENS ORTHOEDIC CLINIC, P.A.
   1765 OLD WEST BROAD STREET ATHENS, GA 30606 (706) 549 1663 (ALSO LOCATED IN LOGANVILLE AND SNELLVILLE)
5. RESURGENS ORTHOPAEDICS
   758 OLD NORCROSS ROAD SUITE 100 LAWRENCEVILLE, GA 30045 (770) 962-4300
6. GWINNETT CLINIC
   1390 WEST SPRING STREET MONROE, GA 30655 (770) 266-6191 (ALSO LOCATED IN LOGANVILLE, WINDER, SNELLVILLE, LAWRENCEVILLE)
7. LOGNAVILLE EYE CENTER
   4495 ATLANTA HW STE 300 LOGANVILLE, GA 30052 (770) 554-3456
8. THE PHYSICIANS SPINE & REHAB SPECIALIST
   5730 GLENRIDGE DRIVE SUITE 100 SANDY SPRINGS, GA 30328 (404) 816-3000 (ALSO LOCATED IN STOCKBRIDGE)
9.

(Additional doctors may be added on a separate sheet)

☐ This box is checked if additional physicians are listed on separate sheet.

IF YOU HAVE 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).

WC-P1 (7/2023)

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.