Mississippi School Boards Association

WC Trust

A Workers' Compensation Program

msba

**WORKERS COMPENSATION**
**FIRST NOTICE OF LOSS**

**EMPLOYEE**

First Name _____

Middle Initial _____

Last Name _____

**ADDRESS**

# and Street _____

City _____

State _____

Zip Code _____

Phone # _____

Date of Birth _____

Social Security# _____

**EMPLOYEE INFO**

Gender (check one):

Male _____ Female _____ Unknown _____

Date hired _____

Occupation/Job Title _____

Employment Status (check one):

Full Time _____ Part Time _____ Temporary _____

**WAGE (To be completed by Central Office)**

Rate (check one):

Day_____ Week_____ Month _____ Other _____

Did salary continue? (check one):

Yes _____ No _____

**OCCURRENCE**

Date of Occurrence _____

Time Employee Began Work:

_____ A.M. _____ P.M.

Time of Occurrence:

_____ A.M. _____ P.M.

Last Day Worked _____

Date Employer Notified _____

Date Disability Began (if applicable) _____

**CONTACT PERSON**

Local School:

First Name _____

Last Name _____

Phone # _____

Type of Injury/Illness _____

_____

Nature of Injury _____

_____

Part of Body Affected _____

_____

Did Injury/Illness occur on Employer's premises? (check one)

Yes _____ No _____

Department or location where accident or illness occurred.

_____

_____

_____

All equipment, materials, or chemicals Employee was using when accident or illness occurred.

_____

_____

_____

Specific activity the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Work process the Employee was engaged in when the accident or illness occurred.

_____

_____

_____

Cause of Injury/Illness _____

_____

_____

Date Returned to work _____

If Fatal, Give Date of Death _____

Were safeguard or safety equipment provided? (check one):

Yes _____ No _____

Were safeguards used? (check one):

Yes _____ No _____

**TREATMENT**

Healthcare Provider:

Name & Address _____

_____

_____

Hospital:

Name & Address _____

_____

_____

**OTHER**

Witness:

First Name _____

Last Name _____

Phone # _____

Date Administer Notified _____

Date Prepared _____

**ADDITIONAL NOTES**

_____

_____

_____

_____

_____

**HIPAA AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, _____, authorize the health care providers identified in paragraph 2 below to disclose protected health information ("PHI") about me as described in this Authorization:

1. The information to be disclosed is all medical documentation, including but not limited to medical history, consultation, prescription, or treatment, copies of hospital records, radiology reports, test results, x-ray, MRI, CT Scan and myelogram films or plates, clinic notes, including diagnostic and prognosis related to my work- related injury of _____("work injury").

2. _____and any other health care provider or facility who treats me for my work injury ("Identified Health Care Providers") may disclose the above-described information to CorVel Corporation and/or Vocational Case Manager or Medical Case Manager employed by CorVel Corporation.

3. This disclosure is made for the following purposes: As requested by the individual for workers' compensation purposes.

4. I understand that the Identified Health Care Providers are not conditioning my treatment, payment, enrollment, or eligibility for benefits on whether I agree to sign this authorization.

5. I understand that the information disclosed pursuant to this authorization may no longer be protected by the federal health privacy rule and may be subject to re-disclosure by the recipient.

6. I understand that I have the right to revoke this authorization in writing at any time by sending a letter to the Privacy Officer of the Identified Health Care Provider and that the effective date of my revocation will be the date the Privacy Officer receives it. I further understand that any revocation will be effective only to the extent that Identified Health Care Providers has not already taken action in reliance on this authorization.

7. This Authorization shall expire twelve months from the date of signature.

_____
Name of Employer (School)

_____
Printed Name (Employee)

_____ _____
Signature (Employee) Date

_____
Witness

_____ _____
Relationship to Employee (supervisor, Principal etc) Date

# NOTICE OF PHYSICIAN CHOICE

Employee's Name: _____

Employer's Name: _____

Injury Date: _____

I am claiming to have sustained an injury involving my _____.
(indicate part of body)

I am _____ am not _____ claiming that my medical condition is work related.
(check one)

If work related:

I understand that under the Mississippi Workers' Compensation Law I have the right to choose one (1) physician to render treatment to me. I can either accept the physician to whom I am sent by employer or choose someone else on my own.

I also understand that any referral to any other doctor must be made by my one chosen physician.

I also understand that my employer (or workers' compensation carrier) must approve any physician change and that if I change doctors without their authorization, I will be responsible for the medical expenses for the unauthorized treatment.

With that understanding, I state as follows:

- ☐ I accept as my choice of physician my employer's suggested physician to provide treatment and that choice is Dr. _____

- ☐ I elect to choose my own physician to provide treatment and that choice is Dr. _____

_____
Employee's Signature

_____
Date

Witnessed By: _____

_____

**Copy to Employee, Employer and CorVel (within 24 hours)**
**CorVel Fax #: 866-434-4720**

**CLARKSDALE MUNICIPAL SCHOOL DISTRICT**
**Dennis Dupree Sr., Superintendent**
**101 McGuire Street**
**P.O. Box 1088**
**Clarksdale, MS 38614**

# EMPLOYEE REFUSAL OF MEDICAL TREATMENT FORM

I have been advised by my Manager/Supervisor that I may seek medical treatment for the injury/accident that may have occurred on the job per the below listed information. I do not think medical treatment is needed at this time, but I will inform my Manager/Supervisor immediately should the need arise.

_____ _____
(Employee Printed Name) (Date of Injury per Employee)

_____
(Time of Injury per Employee)

_____
(Employee List Specific Body Part(s): Example: Right Hand, Index Finger)

_____
(Employee List Specific Injury Type: Example: Scratch, Burn, or Cut)

_____ _____
(Employee Signature) (Today's Date)

_____ _____
(Manager/Supervisor) (Today's Date)

Manager/Supervisor Comments:

_____
_____
_____
_____
_____

Manager/Supervisor Note: Use this form if an employee has a minor injury and they do not feel that they need medical treatment. If the employee's injury is obvious get medical attention and/ or call 9-1-1, if necessary. **Remember to complete the Accident Investigation Report form and fax it immediately to Pam Higginbotham at 662-627-8542 if the employee refuses medical attention.**

**CMSD**

**"Education of Our Children: TOP PRIORITY"**

**Phone: 662-627-8500** **Email: www.cmsd.k12.ms.us** **Fax: 662-627-8542**

**Mississippi School Boards Association**
**Workers' Compensation Trust**

**Voluntary Witness Statement**

Date Occurred:_____ Time Occurred:_____

Name of School/Address of School:_____
_____

Name of Person Giving Statement:_____

Home Address:_____

Work Phone: ( ) _____ Alt Phone: ( )_____

Statement is in regard to (name of person(s) involved in incident, if known):
_____

Location of Occurrence:_____

Did you see the incident occur: Yes or No (circle one)

Written Statement: Please describe in detail what you witnessed on the above date:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I have read this statement and I affirm to the truth and accuracy of the facts contained herein. This statement was completed at :

(location)_____ on the ____ day of _____, 20__ at _____ am/pm

_____ _____
Signature Person Making Statement Date:

_____ _____
Witness to Statement/Title Date