ST. CLAIR COUNTY BOARD OF EDUCATION
ON-THE-JOB INJURY

Procedures for ON-THE-JOB INJURY CLAIMS

- The ON-THE-JOB INJURY FORM must be completed within 24 hours.
  - Any exceptions must be extraordinary in nature,
  - Determined on a case by case basis, and
  - Approved by the personnel director and chief school financial officer.

- If the employee is off due to their injury received while ON-THE-JOB, the PHYSICIAN CERTIFICATION FORM must be turned in to the payroll department within two (2) business days of the injury along with a doctor excuse.
  - Any exceptions must be extraordinary in nature,
  - Determined on a case by case basis, and
  - Approved by the personnel director and chief school financial officer.
  - A PHYSICIAN CERTIFICATION FORM is required for each subsequent doctor visit as long as the employee is off work.
  - Original signature is required from a medical doctor or nurse practitioner.

- The ON-THE-JOB INJURY REPORT and PHYSICIAN CERTIFICATION FORM will be reviewed by the chief school financial officer.

- The board reserves the right to require additional information as well as requirement of the employee to see a doctor of the board's choosing. If requested, this will be paid by the board.

- The employee will receive one of the following if requesting time off for the ON-THE-JOB injury:
  - Approval of the on-the-job absence,
  - Employee is required to provide additional information, or
  - Absence is not approved as an on-the-job injury.

- The employee will receive notification of receipt of the on-the-job injury form if the employee is not requesting time off.

- Employee's Leave:
  - Once an on-the-job injury claim is approved, leave shall not be deducted from the employee if absence from work is found to be a result of an on-the-job injury. Days requested as on-the-job injury <u>will not</u> be considered until <u>all requested documentation</u> has been provided. Days claimed as a result of a repetitive or pre-existing injury will not be granted.

- Our school system does not participate in Workman's Comp Insurance. Claims will need to be filed under employees insurance and reimbursement can be requested.

- If employee is requesting reimbursement for out of pocket expenses, the claim must be filed directly with the Board of Adjustment. Forms can be downloaded at <u>www.bdadj.alabama.gov</u>.

SUBMIT ALL FORMS TO YOUR DIRECT SUPERVISOR

ON-THE-JOB INJURY REPORT

This form must be completed with your supervisor within 24 hours of injury

Name of Injured Employee	Last 4 digits of Soc Sec # XXX-XX-_____	Date of Birth _____/_____/_____	Gender M F
Home Address	Phone (H)_____ (C)_____	Work Location	Job Title
Did employee seek medical treatment as a result of this injury? ☐ YES ☐ NO	If YES, are you requesting time off for the on-the-job injury? ☐ YES how much time?_____ ☐ NO		
Type of Treatment Received: ☐ Emergency Room ☐ Medical/Physician Office ☐ Hospitalized ☐ Paramedics ☐ None			
Date of Injury _____/_____/_____	Time of Injury _____:_____	Date Supervisor Notified _____/_____/_____	
City or Town where injury occurred		Location or place where injury occurred	
Is Employee covered by medical insurance? ☐ YES ☐ NO		Type of insurance	
Name, address and telephone number of attending physician? (if applicable)			
Name, address and telephone number of medical facility where treated? (if applicable)			
Do you feel this injury was caused while fulfilling the duties of your job? ☐ YES ☐ NO Describe in detail what happened to cause the injury:			
Indicate specific body part(s) affected:			
List any witnesses to the injury. Attach a brief signed and dated statement from each witness.			
Signature of injured person			Date
Name of supervisor	Signature of Supervisor	Daytime Phone	Date

Our school system DOES NOT participate in Workman's Comp Insurance. Please bill under employee's insurance. They will be able to request reimbursement with Alabama State Board of Adjustment.

RETURN FORM TO: Tammy Allred ST. CLAIR COUNTY BOARD OF EDUCATION
175 College St. Odenville, ALABAMA 35120
PHONE 205-594-7131, EXT. 2213 FAX 205-594-4202 payroll@sccboe.org

ST. CLAIR COUNTY BOARD OF EDUCATION
PHYSICIAN CERTIFICATION FORM

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Name of Injured Employee: (PLEASE PRINT) _____ (Last) _____ (First) (MI)	Date of Injury: _____/_____/_____ Time of Injury: _____	Date of Birth: _____/_____/_____ Sex: M F	Home Phone_____ Cell Phone_____ Work Phone_____
Home Address:	School: Did injury occur on school grounds?	Job Title:	Job Status: _____Full time _____Part Time/Sub _____Contract
Describe how injury occurred and body part affected:			**Employee Signature:** _____ **Date:**_____

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

Attending Physician (PLEASE PRINT) _____	Medical Facility_____ Address_____Telephone_____	
Employee's Date of Injury _____/_____/_____	Today's Date _____/_____/_____	_____This is patient's 1st visit for this injury _____This is a follow up visit due to this injury

Is there reasonable expectation that the employee should be able to return to work? **YES** **NO**

If **Yes**, date employee can return to work _____/_____/_____

If **No**, please explain_____

Will the employee have any restrictions when returning to work? **YES** **NO**

If **Yes**, please explain restrictions_____

_____

Is employee being referred to another physician for follow up treatment or physical therapy at this time? **YES** **NO**

Is the employee's injury consistent with the above description? YES NO

Is this absence from work a direct result of this injury (not a pre-existing condition)? YES NO

Signature of Physician:_____ **Date:**_____

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