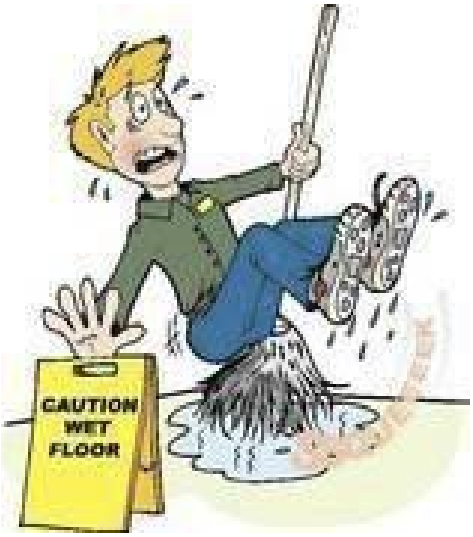
What to do if You are Injured at Work?



1. REPORT IT!

Report your injury immediately to your immediate supervisor or designee.

2. OBTAIN PAPERWORK!

Your immediate Supervisor or designee will complete and provide you a copy of the following:

a. Introduction Letter
b. Employee Injury Data Sheet
c. Employee Acknowledgment Letter
d. Workers' Compensation Prescription Information
e. Form 18 (blank)

All of these forms may be found on the Nash County Public Schools website:
www.ncpschools.net>Departments>Workers' Compensation

3. SEEK MEDICAL TREATMENT!

Seek medical treatment within 48 hours of your injury at one of the approved FastMed Urgent Care locations. ***Emergency Room should be used in life or death accidents only.*** Make sure you present the following documents received from your Supervisor during check in at Urgent Care:

a. The copy of the Employee Data Sheet
b. The Introduction Letter

4. PROVIDE DOCTOR'S NOTES!

Provide doctors' notes to **Sarita Lamm, Workers' Compensation Administrator** at NCPS Central Office, immediately following your appointments.

This may be done by any of the following:

- Drop off at NCPS Central Office front desk, 930 Eastern Ave, Nashville NC;
- Mail to: **Sarita Lamm, Workers' Compensation Administrator**
  930 Eastern Ave
  Nashville, NC 27856
- Fax to (252) 459-6404 **Attn: Sarita Lamm**
- Emailing to: swlamm@ncpschools.net; or

This will guarantee prompt reporting, as well as, prompt scheduling of any referrals to specialists that may be required.

5. FOLLOW DOCTOR'S ORDERS AND GET BETTER SOON!

Follow the doctor's orders. If prescribed medicine, please use the Workers' Compensation Prescription Form that was provided to you.

Questions? Feel free to contact:

Sarita Lamm

Workers' Compensation Administrator

252-459-5220 or swlamm@ncpschools.net

Nash County Public Schools
Nashville, NC

To Whom It May Concern:

This letter is to certify that _____ is currently a(n)
EMPLOYEE'S NAME

_____ at _____.
EMPLOYEE'S POSITION EMPLOYEE'S ASSIGNED SCHOOL or LOCATION

The above named employee was injured on _____ at approximately _____
DATE OF INJURY TIME OF DAY

at _____.
SCHOOL SITE or LOCATION WHERE INURY OCCURRED

This injury may qualify as a Workers' Compensation claim. However, this document does not absolutely confirm that it is a compensable claim. A claim may only be determined to be compensable by Sedgwick Claims Management Services, Inc.

Injured employees should seek treatment from the following medical providers:

FAST MED URGENT CARE
2503 FOREST HILLS ROAD
WILSON, NC 27893
PHONE: 252-991-0555
FAX: 252-991-0596

FAST MED URGENT CARE
2001 SUNSET AVENUE
ROCKY MOUNT, NC 27804
PHONE: 252-458-2508
FAX: 252-210-2833

Sincerely,

Sarita Lamm

Sarita Lamm
Human Resources Department
Workers' Compensation Administrator
252-462-2529
swlamm@ncpschools.net

NASH COUNTY PUBLIC SCHOOLS

I,_____, have been advised of the procedures for seeking medical
(Injured Employee's Name)

treatment for my claimed work-related injury. **The initial provider for work related injuries is FastMed Urgent Care at one of the two (2) locations listed below.** If a referral to a specialty physician is needed, the medical provider below will contact the Workers' Compensation carrier for approval.

FastMed Urgent Care
2001 Sunset Avenue
Rocky Mount, NC
(252) 458-2508

FastMed Urgent Care
2503 Forest Hills Road W.
Wilson, NC 27893
(252) 252-991-0555

Please check one of the options below and sign and date:

___1. I do not wish to seek medical treatment.

___2. I wish to be seen/treated by a doctor for my claimed work related injury. I understand I must seek treatment within 24-48 hours of my claimed work-related injury.

Please forward all paper copies of the medical provider's notes and referrals to:

Sarita Lamm
Human Resources Department
930 Eastern Avenue, Nashville, NC 27856
Phone (252) 462-2529
Fax (252) 459-6404
swlamm@ncpschools.net

In the case of life or death injuries, seek medical attention at the UNC-NGH Emergency Room.

Injured employee's signature: _____Date: _____

Supervisor's signature: _____Date: _____

Nash County Public Schools Employee Injury Data Sheet

Instructions: Injured employee's supervisor or designee immediately completes this form following a work-related injury.
Send completed form to Sarita Lamm, Workers' Compensation Administrator: swlamm@ncpschools.net.

Employee's Name:	**Gender:**	**DOB:**
Home Phone:	**Cell Phone:**	
Address:		
Social Security Number:		
Location/ Department where injury occurred:		
Date of Injury:	**Day of Week:**	**Hour of the day:**
Was the injury on the employee's premises? 'es **No**		
Date supervisor knew of injury:	**Principal's Name:**	
Occupation of injured employee:		
Time the employee started work the day of injury:		
Describe fully how injury occurred and what employee was doing at the time of the injury:		
List all injured body parts and side of body injury affected:		
Is this an Injury Report only? ___Yes ___No	**Did a physician treat the employee?** ___Yes ___No	
Did the employee return to work? ___Yes ___No	**When did the employee return to work?**	

Where did the employee go to treatment? *(Facility name, address, and phone number)*

- *FAST*MED Urgent Care, 2001 Sunset Ave, Rocky Mount, NC 27804 (252) 458-2508
- *FAST*MED Urgent Care, 2503 Forest Hills Rd W, Wilson, NC 27893 (252) 991-0555
- Other, list:

Was this an Emergency Room Visit? ___Yes ___No	**Was this injury due to another person?** ___Yes ___No
Was employee taken by ambulance? ___Yes ___No	**Was this an assault?** ___Yes ___No

Do you question the validity of this claim? ___Yes ___No
If yes, explain why:

List all adult witnesses and phone numbers. *(Include first and last name and title of each)*

Form completed by:	**Date:**
Supervisor's Signature:	**Date:**

Rev. 7/2022

State of North Carolina Department of Public Instruction
Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	PUBLIC SCHOOLS OF NORTH CAROLINA State Board of Education | Department of Public Instruction
Employee Name:	
Group#:	003858
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	GJC6341
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

State of North Carolina Department of Public Instruction has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

		Nash County Public Schools	(252) 459 - 5220
Employee's Name		Employer's Name	Telephone Number
		930 Eastern Ave	Nashville, NC 27856
Address		Employer's Address	City State Zip
		Sedgwick	
City	State Zip	Insurance Carrier	Policy Number
( ) -	( ) -	PO Box 14774	Lexington KY 40512
Home Telephone	Work Telephone	Carrier's Address	City State Zip
- - ☐ M ☐ F	/ /	(919)785 - 5802	(859)225 - 2006
Social Security Number	Sex Date of Birth	Carrier's Telephone Number	Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows:_____ on ___/___/___ at _____. Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Time of Injury Date (required) City and County

Describe how the injury or occupational disease occurred: _____

Occupation when injured:_____ Nature of employer's business: _____

Number of days out of work due to injury:

Medical treatment received? ☐ Yes ☐ No

Weekly wage: $_____ Number of hours worked per day:_____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

				( ) -
Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent	Printed Name of Signer	E-mail Address		Telephone Number
				/ /
Address	City	State	Zip Code	Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FORM 18
3/2022
PAGE 1 OF 2

FOR IC USE ONLY

RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY: _____

FORM 18

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML OR
IF NO IC FILE NUMBER, FOLLOW EMPLOYEE FILING OPTIONS.
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $4,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "3" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.