WORKERS COMPENSATION CHECK LIST

Seeking Medical Attention

- ☐ **Drug Test** – **ONLY** need the Drug Test done if the injured employee is seeking medical attention. **IT IS VERY IMPORTANT THAT THE INJURED EMPLOYEE COMPLETE THE DRUG SCREEN WITHIN 24 HOURS OF REPORTING THE INJURY.** Mark **POST ACCIDENT CHAIN OF CUSTODY** (Bill WORKERS COMPENSATION COMPANY). Have the injured employee sign, print, and date the form. Make a **COPY** of the signed form, give the **ORIGINAL** to the injured employee and send the **COPY** of the signed form with the Workers Compensation packet.

- ☐ **First Report of Injury** – This form is completed by the School ADMINISTRATOR, not the employee.

- ☐ **Injury Statement** – This form is to be completed by the injured employee.

- ☐ **Voluntary Witness Statement** – This form is completed by the person who witnessed the accident. Have the witness complete the form while the details are fresh.

- ☐ **Billing Authorization Form** – This form is completed by the school **(Employee name and Accident Date)** and a copy is provided to the injured employee to provide to the medical facility or physicians office.

- ☐ **HIPPA Medical Authorization Form** – The injured employee completes this form, signs, dates, and gives it to the School Administrator for submission to Human Resources. This form gives the Workers Compensation insurance carrier permission to receive medical information about the injured employee.

- ☐ **Physician of Choice Form** – The injured employee completes this form, signs, and dates the form along with a witness signature for submission to Human Resources.

- ☐ **Pharmacy Choice Form** – The injured employee must complete the form and submit to Human Resources.

- ☐ **MS Workers Compensation Facts booklet –** The School Administrator has provided a copy of the booklet to the injured employee.

- ☐ **Additional Documents** - Were there any pictures or videos of the incident? If so, the School Administrator should submit the additional documents with the Workers Compensation packet and submit it to Human Resources.

- ☐ **Fax the documents to HR at (228) 826-0179 within 24 hours of the employee's injury.**

****NOTE: Failure to file Workers Compensation paperwork within the specified time could result in a fine levied against Jackson County School District by the Mississippi Insurance Department.**

Jackson County School District

P.O. Box 5069

Vancleave, MS 39565

_____ Post-Accident Chain of Custody (bill workers compensation company)

This drug test must be completed within 24 hours of the time of incident.

Testing location: Singing River Clinic (11700 MS-57, Vancleave)

No testing will be done after 3:00 p.m.

Test results should be sent to: JCSD Human Resources Department

Jackson County School District

P.O. Box 5069, Vancleave, MS 39565

Phone # 228-826-0171 or 228-826-0172

Fax # 228-826-0179

email: HR@jcsd.ms

I have read the above information and understand that I must be drug tested within 24 hours of the date of injury. Failure to comply within 24 hours of the date of injury may result in a mandatory hair follicle test.

_____

Signature

_____ _____

Printed Name Date

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)

Jackson County School District
P. O. Box 5069
Vancleave, MS 39565
Phone 228-826-0171 or 228-826-0172

CARRIER/ADMINISTRATOR CLAIM NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | PHONE #

SIC CODE: 8211

EMPLOYER FEIN: 64-6000513

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS & PHONE NO)

MS Municipal WC Group
600 East Amite Street, Suite 200
Jackson, MS 39201

POLICY PERIOD: 10/1/2025 TO 9/30/2026

CHECK IF APPROPRIATE
☑ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

MS Municipal WC Group
Phone# 800-898-1032
Fax# 601-355-8584

CARRIER FEIN | POLICY/SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE) | DATE OF BIRTH | SOCIAL SECURITY NUMBER | DATE HIRED | STATE OF HIRE

ADDRESS (INCL ZIP)

SEX
- MALE (M)
- FEMALE (F)
- UNKNOWN (U)

MARITAL STATUS
- UNMARRIED/SINGLE/DIVORCED (U)
- MARRIED (M)
- SEPARATED (S)
- UNKNOWN (K)

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

PHONE | # OF DEPENDENTS | NCCI CLASS CODE

RATE PER: DAY / WEEK / MONTH / OTHER: | #DAYS WORKED WEEK | FULL PAY FOR DAY OF INJURY? YES NO | DID SALARY CONTINUE? YES NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK AM PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE AM PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO | TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK | IF FATAL, GIVE DATE OF DEATH | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO | WERE THEY USED? YES NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
- NO MEDICAL TREATMENT (0)
- MINOR: BY EMPLOYER (1)
- MINOR CLINIC/HOSP (2)
- EMERGENCY CARE (3)
- HOSPITALIZED > 24 HRS (4)
- FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5)

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE | PHONE NUMBER

SEE BACK FOR INSTRUCTIONS

INJURY STATEMENT
(In your own words)

Name & Contact Number:

Date of Birth:

Email address:

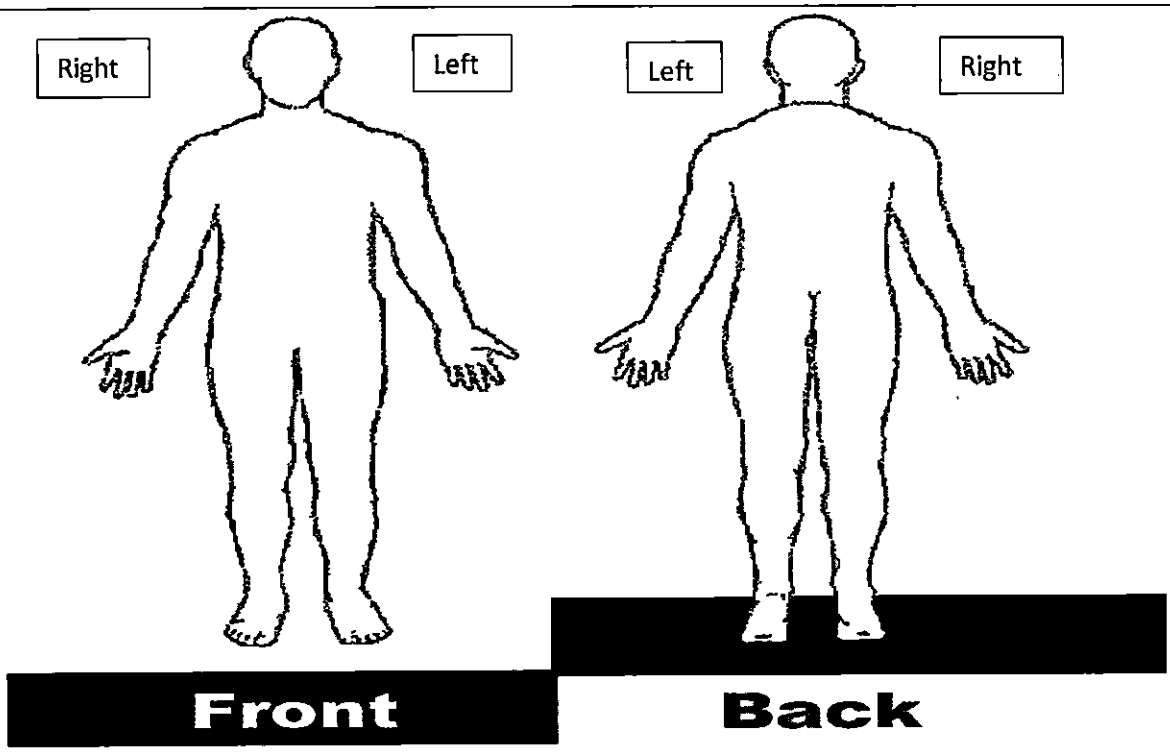
Occupation:

Employer's Name and Address:

Date, Time, and Place of Accident:

Describe in detail what you were doing and what happened when the accident occurred.

Describe your injury & Indicate location of injury on the Body Mapping Chart below:



Name and contact number of witnesses or person(s) having knowledge of accident

VOLUNTARY INCIDENT WITNESS STATEMENT

Injured Employee's Name: _____

Date & Time of Accident: _____

Name of School Campus: _____

Name of Witness: _____

Job Title: _____

Witness Contact Number: _____

Date & Time of Statement: _____

Did you see the incident occur? _____ Yes _____ No

If Yes, please describe what you observed in detail.

I affirm that the information above is complete and accurate to the best of my knowledge.

_____

Signature of Witness

Jackson County School District

Worker's Compensation - Billing Authorization Form

This form should be given to the physician or hospital
THE PHYSICAL OR HOSPITAL MUST NOTIFY
THE EMPLOYER REPRESENTATIVE

DO NOT FILE THIS CLAIM ON THE EMPLOYEE'S PERSONAL HEALTH PLAN

A chain of custody drug screen IS required and results should be sent to:
Jackson County School District
Fax: 228-826-0179 or Email: hr@jcsd.ms

Employee Name: _____

Accident Date: _____

EMPLOYER: Jackson County School District
P O Box 5069
Vancleave, MS 39565

Employer Representatives: Human Resources

- Phone: 228-826-0171 Amy Stewart, HR Coordinator
- Phone: 228-826-0172 Martha Harper, HR Agent
- Phone: 228-826-0174 Karen Glass, HR Director

WORKER'S COMPENSATION CARRIER:
MS Municipal WC Group
600 East Amite Street, Suite 200
Jackson, MS 39201
Phone: 1-800-898-1032

MISSISSIPPI MUNICIPAL SERVICE COMPANY

HIPAA Medical Authorization Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND REPORTS

FULL NAME: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NO:** _____

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, and pharmacies, to release all existing medical records and information regarding the above referenced patient's medical care, treatment, physical/medical condition, and medical expenses revealed by your observation or treatment of past, present and future to the MISSISSIPPI MUNICIPAL SERVICE COMPANY or its representative, or the bearer hereof, or the bearer of any photo static or Xerox copy hereof.

I understand that this authorization includes information regarding the diagnosis and treatment of drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), and psychiatric and psychological disorders (EXCEPT *Psychotherapy Notes * as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501, psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record.* Psychotherapy notes require a separate authorization.) It also includes x-ray reports, laboratory reports, CT scan reports, MRI scans, EEG's, EKG's, sonograms, arteriograms, fetal monitor strips, discharge summaries, photographs surgery consent forms, informed consent forms regarding family planning, admission and discharge records, operation records, doctor and nurses notes, prescriptions, medical and any correspondence/memoranda and billing information. It also includes, to the extent such records currently exist and are in your possession, insurance records, including Medicare/Medicaid and other public assistance claims, applications, statements, eligibility material, claims or claim disputes, resolutions and payments, medical records provided as evidence of services provided, and any other document or things pertaining to services furnished under Title XVII of the Social Security Act or other forms of public assistance (federal, state, local, etc). This listing is not meant to be exclusive.

I, the undersigned individual, am on notice that:

(1) Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.

(2) Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

(3) This authorization can be revoked through written notice to MISSISSIPPI MUNICIPAL SERVICE COMPANY, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.

(4) A photocopy of this authorization shall be considered as effective and valid as the original and this authorization will remain in effect for five (5) years from the date of the authorization.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, _____, to those persons or agencies listed above.

Date: _____

Patient or Patient Representative _____
(Signature)

Name of Patient's Representative _____
(Print Name)

Relationship _____

_____
Description of Representative's Authority to Act for the Patient

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

**Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.*

MISSISSIPPI MUNICIPAL SERVICE COMPANY

NOTICE TO THE MISSISSIPPI WORKER'S COMPENSATION COMMISSION OF

PHYSICIAN OF CHOICE

Employee's Name: _____

Employer's Name: _____

Date of Alleged Injury: _____

Claim Number: _____

I am claiming to have sustained an injury involving my _____

I am _____ am not _____ claiming that my medical condition is work related.

I understand that under the MS Worker's Compensation Law I have the right to choose one (1) physician to render treatment to me.

I also understand that any referral to any other physician must be made by my one (1) chosen physician.

I also understand that my employer (or Worker's 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 tender of treatment by

Dr. _____

_____ I elect to choose my own physician to render treatment, and that choice is

Dr. _____

_____
Employee's Name Printed

_____
Employee's Signature

_____
Date

Witnessed by:

_____

_____

This Form Should Be Completed By Injured Employee Only

MISSISSIPPI MUNICIPAL SERVICE COMPANY

PHARMACY CHOICE

Instructions: Please complete this form to designate your preferred pharmacy for filling prescriptions related to your workers' compensation claim. Our billing company, Carlisle Medical, will notify your pharmacy to prevent delays in filling your medications.

Employee's Name: _____

Employer's Name: _____

Date of Alleged Injury: _____

Claim Number (if known): _____

Preferred Pharmacy Information:

Pharmacy Name: _____

Pharmacy Address: _____

City, State, ZIP: _____

Pharmacy Phone Number: _____

Important Information for Claimants:
If you need to change your preferred pharmacy at any time, please contact Mississippi Municipal Service Company at 601-355-8581 or 1-800-898-1032.

Acknowledgment and Signature:
By signing below, I acknowledge that I have designated my preferred pharmacy for my workers' compensation prescriptions.

Signature: _____ Date: ____/____/_____

Please return this form with your initial claim documentation or submit it to:
Mississippi Municipal Service Company
600 East Amite Street, Suite 200
Jackson, MS 39201

Phone: 601-355-8581
Fax: 601-355-8584

[THIS FORM SHOULD BE COMPLETED BY THE INJURED EMPLOYEE ONLY]

Mississippi Worker's Compensation Commission
1428 Lakeland Drive / Post Office Box 5300
Jackson, Mississippi 39296-5300
(601) 987-4200
http://www.mwcc.state.ms.us

2013

MISSISSIPPI WORKERS'

COMPENSATION

FACTS

WHAT IS WORKERS' COMPENSATION?

Workers' compensation is essentially a no-fault insurance plan mandated by State law, supervised by the Workers' Compensation Commission and paid for entirely by employers. The Workers' Compensation Law was enacted by the Legislature in 1948 to guarantee the payment of certain medical and wage loss benefits to persons injured on their job. As part of this Law, the Workers' Compensation Commission, with its office in Jackson, MS, was established to supervise and monitor claims which arise under the Law. An employer covered by the Law is required to secure the payment of workers' compensation benefits to its employees by purchasing workers' compensation insurance from an insurance company or by obtaining approval from the Commission to self-insure.

WHO IS COVERED?

Most working Mississippians are protected by the Workers' Compensation Law, but there are exceptions. All employers with five (5) employees regularly employed are required to provide workers' compensation insurance coverage. If the employer has less than five (5) employees, workers' compensation coverage is not mandatory but may be provided voluntarily by the employer. Domestic and farm labor, and employees of non-profit fraternal, charitable, religious or cultural organizations are not covered under the Law unless coverage is provided voluntarily by the employer. The Workers' Compensation Law likewise does not apply to federal employees or certain transportation and maritime employments covered by federal compensation laws. Finally, independent contractors are ordinarily excluded from coverage although special protection is given to employees of subcontractors.

WHAT IS COVERED?

Any injury, however slight or serious, is covered if it arises out of the course and scope of employment. Occupational illnesses and diseases are also covered if job-related, as are work related deaths.

WHEN DOES COVERAGE BEGIN?

The worker is covered and eligible for benefits as soon as he or she begins employment. There is no waiting period or minimum earnings requirement.

WHAT MUST AN INJURED WORKER DO IN THE EVENT OF INJURY?

In the event of an injury, you should immediately notify your supervisor or other person designated by your employer. Prompt and accurate reporting is essential. Your employer is then required to make a report of the injury and notify its insurance company and/or the Workers' Compensation Commission. An injured employee should try to give the employer notice of the injury within 30 days. If no disability benefits are paid to the injured worker by the employer or carrier within two (2) years of the date of injury, then the right to any and all benefits is barred unless the employee files a claim with the Commission during this two (2) year period. This is what is known as the two (2) year statute of limitations.

PLEASE BE ADVISED:

"Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under [the Workers' Compensation Law] is guilty of a felony and on conviction thereof may be punished by a fine not to exceed Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or by imprisonment not to exceed three (3) years, or by both fine and imprisonment."

WHAT BENEFITS ARE AVAILABLE?

The Workers' Compensation Law provides two basic benefits to the injured worker:

- *Medical Benefits.* An injured worker is entitled to whatever reasonable and necessary medical services are required to treat the injury and achieve maximum cure. These include but are not limited to doctor and hospital services, nursing services, medication, physical therapy, crutches and any other apparatus or medical service which is necessary. Mileage expense reimbursement for trips to the doctor is also included; consult the Commission's internet site at www.mwcc.state.ms.us for current rates. Certain rehabilitation services may also be provided to assist the worker in his recovery and return to gainful employment.

- *Wage Loss Benefits.* If an injured worker is required because of the injury to miss time from work, then he or she is entitled to a wage loss benefit equal to as much as two-thirds of the workers' average weekly wage, subject a maximum weekly amount and to certain time limits which are set by the Legislature. While the worker is under the continuing care of a doctor and is unable to work or to earn full pay, this benefit is known as a "temporary disability" payment. Once the doctor finds the worker has achieved maximum cure or improvement, additional wage loss benefits known as "permanent disability" payments may be due if the worker has a permanent disability or handicap. All wage loss benefits are required to be paid at least every 14 days so long as the covered disability continues, subject to certain statutorily provided time limits.

WHAT IF DEATH OCCURS?

If the injury causes death, the Workers' Compensation Law guarantees the payment of benefits to any surviving spouse and certain surviving dependents. These benefits are payable at least every 14 days, and may continue for up to 450 weeks after the decedent's death. These benefits equal a certain percentage of the deceased worker's average weekly wage, and are subject to a weekly maximum amount set by statute. Also, the employer or its insurance carrier is obligated to pay up to $5,000.00 in funeral expenses, as well as an immediate lump sum payment of $1,000.00 to the surviving spouse.

MORE ABOUT MEDICAL BENEFITS.

The Workers' Compensation Law provides that an injured worker has the right to select one physician or medical provider of his or her own choosing to render treatment. This chosen provider may make one referral of the worker to another specialist to continue treatment without any approval from the employer or its insurance carrier. However, any additional selections or referrals must be approved in advance by the employer or its insurance carrier. The worker is not limited to a licensed medical doctor and may choose, for example, a chiropractor for treatment. The worker is also entitled to mileage reimbursement for trips to the doctor.

IS THERE A DEDUCTIBLE?

There is no deductible to be paid by the worker for any of the benefits received. An employer may have a deductible arrangement with its insurance company, but all workers' compensation benefits are provided at no cost to the employee.

PLEASE BE ADVISED:

"Any employee receiving [medical] treatment or service under the [Workers' Compensation Law] may not be held responsible for any charge for such treatment or service, and no doctor, hospital or other recognized medical provider shall attempt to bill, charge or otherwise collect from the employee any amount greater than or in excess of the amount paid by the employer, if self-insured, or its workers' compensation carrier."

"No agreement by an employee to pay any portion of premium paid by his employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing compensation or medical services and supplies as required by [the Workers' Compensation Law] shall be valid. Any employer who make a deduction for such purpose from the pay of any employee entitled to [workers' compensation] benefits . . . shall be guilty of a misdemeanor. . ."

HOW ARE PAYMENTS MADE?

All payments are made by the employer or its insurance company, *not* by the Workers' Compensation Commission. Medical payments should be made directly to the doctor or other medical provider by the employer or its insurance company. Wage loss payments should be made directly to the injured worker or the workers' legal representative. Once started, wage loss or disability payments to the worker should be made at least every 14 days until concluded.

ARE BENEFITS PAID FOR ALL DAYS MISSED FROM WORK?

Medical benefits are paid regardless of the number of days missed from work. If the injured worker suffers fewer than 14 days of disability (days on which the worker is unable due to injury to earn his regular wage) as the result of a job related injury, wage loss payments are not made for the first 5 days. Payment will be made only for the number of days of disability in excess of 5. This is known as the 5 day waiting period. If the worker suffers 14 or more days of disability, then wage loss payments are made for the total period of disability, including the first 5 days.

HOW MUCH ARE WAGE LOSS PAYMENTS?

Depending on the nature of the injury and disability, payments will be as much as two-thirds of the workers' average weekly wage, subject to a maximum weekly amount set by the Legislature. No worker is entitled to receive more than 450 times the maximum weekly amount established by the Legislature, regardless of the type of injury. In death cases, this limit applies to the total of payments to spouse and dependents.

Effective for injuries or fatalities occurring on or after January 1, 2013, the maximum weekly benefit for disability or death is $449.12. The maximum overall limit is 450 times this amount, or $202,104.00. These figures represent the maximum amount which can be paid for an injury or death. Depending on one's average weekly wage, benefits may be less, since you are entitled to the lesser of 2/3 of your average weekly wage or the weekly maximum in effect at the time of your injury. Please consult the minimum/maximum benefits chart available at *www.mwcc.state.ms.us* for the maximum benefit rate for years other than 2013.

HOW LONG WILL WAGE LOSS PAYMENTS CONTINUE?

For a worker permanently and totally disabled, payments will be made for a maximum period of 450 weeks. For injuries which result in less than permanent and total disability, the time limit for payments varies according to the nature of the injury and disability. In cases of death, payments to dependents may not exceed 450 weeks.

WHAT IF THERE IS A PROBLEM?

If you encounter a problem with the way your claim is being handled, or you think you have not received all benefits due, first contact the employer or insurance company representative handling your claim. Many problems can be cleared up with a phone call. Remember, if your claim is accepted and paid, it will be paid by the employer or its insurance carrier and not by the Workers' Compensation Commission. If the problem cannot be resolved in this manner, you may contact the Mississippi Workers' Compensation Commission at 601-987-4200 and ask to speak with a Claims Representative. A Claims Representative may be able to help you resolve your problem.

DOES THE INJURED WORKER NEED AN ATTORNEY?

Fortunately, the majority of claims are handled routinely and without any dispute. However, there are instances when you may not be able to resolve disputes yourself or through a Claims Representative of the Commission. In such cases, the assistance of an attorney can be invaluable. You are not required to hire an attorney, but you may consult with and hire an attorney of your own choosing at anytime. Most attorneys are paid by retaining a percentage of the compensation you receive after the attorney is hired. So long as your claim is pending before the Commission, an attorney may not retain more than 25% of the total compensation paid to you. If your claim is appealed to a court of law, up to 33 1/3% of the total compensation may be set aside for attorney's fees.

SAFETY IS IMPORTANT!

While the Workers' Compensation Law exists to guarantee certain benefits for persons who sustain bona fide work related injuries or illnesses, these benefits are limited and often will not make the injured person whole again. Prevention is the most valuable benefit and every worker should strive to prevent an injury from occurring. By adhering to safe work practices, many injuries can be prevented.