



Clayton County Public Schools Workers' Compensation Claim Process

Your responses must be detailed, complete, and legible.

Read all the questions and provide your answers.
Remember to sign and date each form where indicated.

If you have questions, please contact:

Leslie Harris Leslie.Harris@clayton.k12.ga.us Office: 770-473-2738 District Cell: 404-450-7977	Stephanie Cosby Stephanie.Cosby@clayton.k12.ga.us Office: 770-473-2752 District Cell: 470-345-9133	Latasha Lowe Latasha.Lowe@clayton.k12.ga.us Office: 678-817-3086 District Cell: 770-238-9165
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Department Fax: 770-472-8471

How Does the Claim Process Work?

Answer Every Question on Every Page!!!

- In the event of a work-related injury, you must immediately report the incident to your supervisor or bookkeeper on the same day it occurs, either in person or by phone.
- If you are experiencing a medical emergency, call an EMT. Once the emergency has passed, follow the next steps.
- You will then have the option to file a claim or decline to do so. If you choose to decline, the supervisor or bookkeeper must send an email to E&C Risk Management, informing them that you were offered the option to file a claim but chose not to. **Remember, if you decline to file a claim, you may lose the opportunity at a later date.**
- If you decide to file a workers' compensation claim, you will work with the claims facilitator (supervisor or bookkeeper) to complete the claim form. Take your time to read and answer all questions carefully. Remain with the facilitator.
- Don't delay the submission of the claim, waiting for a witness statement; it can be submitted later if necessary.**
- The facilitator (supervisor or bookkeeper) will then scan ALL pages 1-7 of the claim and send them to Leslie Harris, cc Stephanie Cosby, and cc Latasha Lowe for review. You will wait with the facilitator during this process.**
- If the claim is deemed compensable AND ACCEPTED, the employee, bookkeeper, and supervisors will receive an email authorization.
- Following AUTHORIZATION, you will be required to leave the worksite and report for a mandatory drug and alcohol test, which must be completed within two (2) hours of the injury. If you request and accept, medical care will also be made available to you.**
- Additionally, the claim will be filed with the GA State Board of Workers' Compensation.

The employee must stay with the supervisor or bookkeeper until the workers' compensation claim is processed. Never send an employee to a clinic without authorization from CCPS Risk Management; they will not be seen.



Never force an employee to file a claim.

Once This Claim Has Been Submitted and Accepted
THE EMPLOYEE WILL NOT BE ALLOWED TO WITHDRAW IT.

Board Regulation GAMA-R (1) Drug-Free Workplace - Workers' Compensation Injuries - All Workers'
Compensation injuries will require a drug/alcohol test to be administered within two (2) hours of the reported injury. The results of any testing are confidential as provided by federal or Georgia laws. Positive results will be addressed in accordance with the guidelines of Board policy GAMA - Drug-Free Workplace. Refusal to submit to a drug test shall be considered a positive and will result in the denial of the injury claim. Additionally, the refusal may lead to appropriate disciplinary action, up to and including termination.

WC Claim Form

1. Date the injury occurred: (MM/DD/YYYY):		2. Time the injury occurred: ____:____ Circle AM or PM	
3. Your Employee ID Number:		4. Circle Your Gender: Male or Female	
5. Your First Name:		6. Your Last Name:	
7. Your Home Address:			
8. City:		9. State:	
11. Your Cell Phone #:		10. Zip:	
12. Your Home Phone #:		13. Your Work Phone #:	
14. Your PERSONAL Email:		15. Your Scheduled Lunch Break (start of lunch break to end of lunch break):	
16. Your Daily Shift Time (start of work shift to end of work shift):		17. Your Date of Birth:	
18. Are you required to remain in the building during your lunch break? Circle YES or NO		19. Your Job Title:	
20. Your Department & Location:			
21. Your Supervisor's Full Name (first & last):			
22. Circle Your Employment Classification: Full-Time / Part-Time / Substitute			
23. In the boxes provided BELOW, List ALL the body parts you injured. Then Circle left, right, or both			
This is an Example: Left , Right/Both Arm			
1. Left / Right / Both	2. Left / Right / Both	3. Left / Right / Both	4. Left / Right / Both
5. Left / Right / Both	6. Left / Right / Both	7. Left / Right / Both	8. Other:
24. Have you EVER previously had an injury to any of the body parts listed above or been treated by a doctor for ANY body parts listed above? Circle YES or NO *** If YES - When did it occur? _____ Where or who treated? _____ Are you still being treated? circle Yes or No?			
25. Here you will Explain <u>in detail how you were injured</u> , including where you were, what you were doing, and what happened to cause the injury to each body part you listed above on item #23.			
Do not use students' names!!!			
A. Where were you or where were you going?			
B. What were you doing?			
C. What happened to cause an injury to <u>each</u> body part listed above in question #23?			
Continued on next page			

WC Claim Form Continued

D. On a scale of 1 to 5, with five being the highest, how would you rate your pain level? Circle one: 1 2 3 4 5

E. Were there any cameras in the location where you were injured? Circle YES NO or Unknown

Additional Writing Space is Provided Below

26. Before submitting this claim to your supervisor or bookkeeper, who will then forward it to Equity and Compliance Risk Management, **please Review Page 2, Item #23.** Carefully evaluate your injuries to ensure that you have listed every body part that requires medical attention. **If you have reviewed and affirmed that all injured body parts are included, please Indicate with Your Initials:** _____

Answer ALL Questions Below

27. Did you report this injury to a supervisor or bookkeeper within 2 hours of its occurrence as required by CCPS Board Regulation GAMA-R (1)? Circle Yes or No

If NO, why not?

28. Who and when did you report your injury to, and at what time?

Who:

When:

What Time:

Were you offered the opportunity to file a WC claim?

Circle Yes or No

29. Based on today's report of your injury, are you scheduled to be off tomorrow for Any Reason?

Circle Yes or No

30. Did you receive and sign the document titled "How to Report a Work Injury and File a Workers' Compensation Claim at Clayton County Public Schools"?

Circle Yes or No

31. Were Any ADULT Witnesses Present? Circle Yes or No

If applicable, please list the full names of any witnesses below. If they are available, ask them to complete page 7 (the witness statement form). **Do not delay submitting this claim if the witness is unavailable** to complete page 7, as that page can be submitted later.

Witness #1 First and Last Name: _____

Witness #2 First and Last Name: _____

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

Print Employee Name:

Employee ID Number:

Employee Signature:

Today's Date:

WC Medical History Form

GINA DISCLOSURE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, **we ask that you not provide any genetic information when responding to this request for medical information.** "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Have you **EVER** had problems with or been treated for **ANY** of the following conditions or diseases?

↓ Circle "Y" FOR YES OR "N" FOR NO ↓

Amputation	Y N	Neck Injury/Pain or problems	Y N
Ankylosis Immobility for any major weight bearing joints (ankles, knees, hips)	Y N	Broken Bones	Y N
Arm/Elbow Injury/Pain	Y N	Chest Pains	Y N
Arthritis or rheumatism	Y N	Diseased process of the spine	Y N
Back Injury/Pain or surgery	Y N	Epilepsy, fainting spells or dizziness	Y N
Cancer	Y N	Frequent Headache/Dizziness/Migraines	Y N
Cardiovascular Disorders	Y N	Herniated/Slipped Disk	Y N
Cerebral Palsy	Y N	High Blood Pressure	Y N
Compressed Air Sequelae	Y N	Hyperinsulinism	Y N
Depression, anxiety, or other diagnosed mental health disorders	Y N	Joint Pain	Y N
Diabetes	Y N	Knee Injury/Pain or surgery	Y N
Do You Wear Glasses	Y N	Multiple Sclerosis	Y N
Epilepsy	Y N	Muscular Dystrophy	Y N
Foot/Ankle Injury/Pain	Y N	Parkinson's Disease	Y N
Hand Injury/Pain	Y N	Poliomyelitis	Y N
Head Injury/Pain or surgery	Y N	Pulmonary Disease	Y N
Hearing or vision Loss	Y N	Repetitive motion disorders	Y N
Heart Disease	Y N	Rotator Cuff Injury or surgery	Y N
Hemophilia	Y N	Ruptured Disc	Y N
Hip Injury/Surgery	Y N	Shoulder Injury or pain	Y N
Respiratory problems such as asthma, allergies or lung disease	Y N	Tuberculosis	Y N
Sickle Cell Anemia	Y N		
Surgical removal of disc or spinal fusion	Y N		
Tendonitis/bursitis	Y N		
Wrist Problems (including Carpal/Cubital Tunnel Syndrome)	Y N		

2. Have you **Ever** had any prior surgeries or sought treatment from a healthcare provider for any medical conditions listed above? **Circle Yes or No**

If yes, explain:

3. Have you **Ever** received a **disability or impairment rating** from a physician? **Circle Yes or No**

If yes, when, what for, and what %?

4. Do you have **Any** pre-existing diseases, conditions, or permanent impairments in which your doctor has given you physical limitations/restrictions? **Circle Yes or No** If yes, please explain.

5. **Did you complete** a Medical Questionnaire when hired? **Circle Yes or No**

6. Are you required to complete a yearly physical in association with your employment? **Circle Yes or No**

7. **Before today**, have you **EVER** filed a workers' compensation claim? **Circle Yes or No**

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

Employee Signature:

Date:

Employee ID #:

WC Posted Panel of Physicians Form

WHAT IS A POSTED PANEL OF PHYSICIANS?

A Workers' Compensation Posted Panel lists the authorized treating physicians selected by the employer to treat injured workers. Below is the list of doctors (also posted at your worksite) from whom employees may seek treatment if injured on the job at Clayton County Public Schools. A minimum of six doctors is to be listed, representing six different medical practices. In addition, every employer with more than three employees must post a panel of physicians that contains the names and addresses of at least six unassociated doctors or clinics. The treating doctor of your choice will become your authorized treating physician, supervise your treatment, and liaise with any other approved providers.

You Must **Select/Circle Only One** Authorized Treating Physician from the Posted Panel Provided Below

THESE MEDICAL CENTERS PROVIDE **IMMEDIATE CARE**

IMMEDIATE CARE 678-422-8824 Concentra Occupational Medicine Morrow Location 1500 Mt. Zion Road Morrow, GA 30260 Mon - Fri: 7:30 AM - 6:00 PM Sat: 9:00 AM - 3:00 PM	IMMEDIATE CARE 404-768-3351 Concentra Occupational Medicine Hapeville Location 3580 Atlanta Avenue Hapeville, GA 30354 OPEN 24 HOURS Mon - Fri: 12:00 AM - 11:59 PM Sat - Sun: 12:00 AM - 11:59 PM	IMMEDIATE CARE 404-881-1155 Concentra Occupational Medicine Atlanta Location 688 Spring Street Atlanta, GA 30308 Mon - Fri: 8:00 AM - 5:00 PM	
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THESE MEDICAL CENTERS WORK BY **APPOINTMENT ONLY**

When an employee chooses a clinic that operates on a "BY APPOINTMENT ONLY" basis, it may take a few days to secure an appointment. During this time, the employee will be sent to a designated clinic for the drug and alcohol test. Immediate medical care will also be offered until an appointment is arranged with the preferred physician. The Claims Department will contact you to schedule the appointment. We appreciate your patience.

BY APPOINTMENT ONLY 770-389-8386 Georgia Bone and Joint General: Dr. Carl Sutton, III Upper Extremity & Hands: Dr. Burke 145 Medical Boulevard Stockbridge, GA 30281 Mon - Fri: 8:30 AM - 5:00 PM	BY APPOINTMENT ONLY 404-355-0743 Peachtree Orthopedic Back: Dr. Langenbeck Lower Extremity: Dr. Bernot Lower Extremity: Dr. Lahiji Upper Extremity: Dr. McCollam Sports Medicine: Dr. Kimmerly 1901 Phoenix Blvd. Suite 200 College Park, GA 30349 Mon - Fri: 8:00 AM - 5:00 PM	BY APPOINTMENT ONLY 404-264-6701 Atlanta Neurological & Spine Institute Spine: Dr. Edwards 11 Upper Riverdale Rd. Riverdale, GA 30274 Mon - Fri: 8:00 AM - 4:00 PM	BY APPOINTMENT ONLY 770-968-8888 Clayton Eye Center Ophthalmology 1000 Corporate Center Dr. Suite 100 Morrow, GA 30260 Mon - Fri: 8:00 AM - 5:00 PM Sat: 8:30 AM - 12:00 PM (Noon)
BY APPOINTMENT ONLY 770 626-5340 Georgia Bone and Joint Back, Neck, & Spine: Dr. Kessler General: Dr. Walker Hip & Knee: Dr. Desai Foot & Ankle: Dr. Henisch 125 Grand Oak Drive Fayetteville, GA 30214 Mon - Fri: 8:30 AM - 5:00 PM	BY APPOINTMENT ONLY 404-425-1043 Peachtree Orthopedic Back: Dr. Cassinelli Physical Medicine: Dr. Schiff Sports Medicine: Dr. Kimmerly 2001 Peachtree Rd Suite 705 Atlanta, GA 30309 Mon - Fri: 9:00 AM - 5:00 PM	BY APPOINTMENT ONLY 404-256-3720 Atlanta Neurology Neurologist: Dr. Gwynn 990 Hammond Drive Suite 325 Atlanta, GA 30328 Mon - Fri: 9:00 AM - 4:00 PM	

Changing Your Authorized Treating Physician

If you become dissatisfied with your initial choice of treating physician during treatment, you may select an alternate doctor from the posted panel of physicians listed above. This is referred to as your **"One-time Change."** The one-time change will require submission of a WC 200 - a CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT BY CONSENT FORM.

I have read the information provided about the Posted Panel of Physicians. I have indicated my choice by circling it above. I understand that a representative from the Risk Management Unit of the Equity and Compliance Division must authorize my medical treatment. If I seek treatment from anyone **not approved** and **listed** on the panel above, I will be responsible for the medical bills. I affirm that I have read and understand this information. My signature certifies that all facts, selections, and representations I have made are true, accurate, and are made willingly and intentionally.

Employee Signature:

Date:

Employee ID #:

WC Benefits Choice Form

IF I SUFFER AN ECONOMIC DISABILITY, HOW MUCH WILL MY WEEKLY BENEFITS BE?

You will receive two-thirds of your average weekly wage, but not more than \$800.00 per week, for an accident that occurred on or after July 1, 2023. Please refer to the GA State Board of Workers' Compensation Bill of Rights for the injured worker, which is posted in your building and available online.

WHEN DO I RECEIVE BENEFITS?

Disability begins on the first day that you are unable to work a full day due to a compensable injury and are not fully compensated. You are entitled to benefits after a 7-day waiting period, excluding Saturdays and Sundays. If your absence lasts more than 21 consecutive calendar days (including Saturdays and Sundays), you will receive payment for the initial waiting period. Your first Temporary Total Disability (TTD) check will be mailed within 21 consecutive calendar days from the start of your disability.

OR CCPS WILL ALLOW THE USE OF SICK LEAVE DURING YOUR RECOVERY

When you cannot work, you are entitled to weekly Workers' Compensation income benefits; however, you may opt to use available Sick Leave instead. In addition, you may submit an email request to the Risk Management Unit of the Equity and Compliance Division to use your available Annual Leave when all Sick Leave is exhausted.

You Must **Check One Option** Below

Please Read Each Option carefully and check the one that best suits your needs. **You will always have the right to change your selection**, but you must do so by contacting **Leslie Harris** (Leslie.Harris@clayton.k12.ga.us), **Stephanie Cosby** (Stephanie.Cosby@clayton.k12.ga.us), and **Latasha Lowe** (Latasha.Lowe@clayton.k12.ga.us) to request a change, which will require the completion of a new WC Benefits Choice Form. If employees miss ten or more consecutive days of work, they are required to speak with HR Absence Management to discuss their leave. During this conversation, they will be informed of their rights and responsibilities. For employees who qualify for leave, it will be administered concurrently with any absence related to a reported work injury.

OPTION 1 _____ I elect to use my available Sick Leave for the entire period of my recovery. I understand that I will continue to receive compensation via the use of available sick leave from the CCPS payroll department. The bookkeeper will classify my time off as WC Sick Leave until either I return to work or my sick leave is fully exhausted. If my sick leave is exhausted, my absence will be classified as Workers' Compensation Leave Without Pay (WC LWOP), and I will then receive a weekly Temporary Total Disability (TTD) check, which will be mailed to my home address.

Once Coded WC LWOP, I understand that **I will not be paid via the CCPS payroll department**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions.

OPTION 2 _____ I elect to use my available Sick Leave for the first seven days of my recovery. I understand that I will continue to receive compensation from the CCPS payroll department via the use of available sick leave for 7 business days, and the Bookkeeper will classify my absence as WC Sick Leave. Beginning on the 8th business day of my absence, my status will then change to WC LWOP (Leave Without Pay) until I return to work. Once coded as WC LWOP, I will receive a weekly TTD (Temporary Total Disability) payment, which will be mailed to my home address.

Once Coded WC LWOP, I understand that **I will not be paid via the CCPS payroll department**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions.

OPTION 3 _____ I elect IMMEDIATE USE of Workers' Compensation Disability Benefits; I do not wish to use any sick leave. I understand that the Bookkeeper will classify my absence as Workers' Compensation Leave Without Pay (WC LWOP) for the entire duration of my absence. As a result, beginning on the 8th day of my disability, I will receive a weekly TTD (Temporary Total Disability) check, which will be mailed to my home address. I will no longer receive compensation from the CCPS payroll department. If my absence extends beyond 21 calendar days, I will then be compensated for the first 7 days.

Once Coded WC LWOP, I understand that **I will not be paid via the CCPS payroll department**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions. first 7 days.

I have read and understood the information provided above. I recognize that any future changes must be authorized by a representative from the Risk Management Unit of the Equity and Compliance Division. I agree that if I am overpaid for Workers' Compensation Benefits by Georgia Administrative Services or overpaid by the Clayton County Public Schools Payroll Department, I must repay those funds. If I refuse to return any overpayment, I understand that Georgia Administrative Services and Clayton County Public Schools may deduct these amounts from my future Workers' Compensation benefits and payroll checks. My signature confirms that all the facts, selections, and representations I have made are true, accurate, and given willingly and intentionally.

Employee Signature:

Date:

Employee ID #:

WC Witness Statement Form

Make Additional Copies Where Necessary

This page should be left blank if there were no witnesses

Adults Only (Students may not complete this form)

**** DON'T DELAY THE SUBMISSION OF THE CLAIM, WAITING FOR A WITNESS TO COMPLETE THIS FORM****
WITNESS STATEMENT FORMS MAY BE SUBMITTED LATER WHEN/IF NECESSARY

The Adult Witness must complete the information below.

The Witness Full Name:		The Witness Employee ID Number:	
The Witness Home Address:	City:	State:	Zip:
The Witness Job Title:		The Witness Phone Number:	
The Witness Work Location and Supervisor:			

Please share your firsthand witness testimony below.

The Injured Employee's First and Last Name:

The date of the injury:	The time <u>you</u> Witnessed the injury: _____ : _____ Circle AM or PM
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1.

Where did the incident occur, be exact?

2.

Please **describe in detail** what you **observed and heard**, and explain what assistance you provided.

3.

Who did you inform about witnessing the incident that took place?

4.

Is there any other information you would like to share about what you observed?

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

The Witness Signature:	Date:
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