



RCSS WORKERS' COMPENSATION PACKET

Your health, safety, and well-being are extremely important to us. If you experience a work-related injury or illness, the Richmond County School System is committed to supporting you throughout the Workers' Compensation process. This packet is designed to provide clear guidance and ensure that all required steps are completed accurately and efficiently.

To help you navigate the process, please follow the steps below:

Steps to Complete Your Workers' Compensation Packet

1. **Report the injury immediately** to your supervisor, no matter how minor it may seem.
2. **Complete the Employee Accident Report and Authorization and Consent to release Medical Information** forms as soon as possible after the incident.
3. Your **supervisor** will **complete the Supervisor Report** and collect any required witness statements.
4. If medical treatment is needed, your supervisor will provide you with the **Employer Notification for Treatment** form and assist you in selecting a provider from the **Panel of Physicians**.
5. All completed documents must be submitted promptly to the **Workers' Compensation Specialist**, Mrs. Curlisha Mays, at mayscu@boe.richmond.k12.ga.us. She will review the information and open a claim.
6. If you receive medical care, please follow all provider instructions and keep us informed about work restrictions or return-to-work status.

Our Workers' Compensation team is here to assist you throughout this process. We are committed to ensuring that your claim is handled with care, accuracy, and respect.

If you have questions or need further support, please contact our Workers' Compensation Specialist, **Mrs. Curlisha Mays** at **706-826-1000 ext. 5523**. We are here to help you stay safe, supported, and informed.

Thank you for your attention to these procedures and for your continued service to Richmond County students and families.

Sincerely,

Dr. Melissa W. Shepard
Chief Human Resources Officer



EMPLOYEE ACCIDENT REPORT

Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony in the third degree and is therefore subject to penalties of up to \$10,000 per violation (O.C.G.A. 34-9-18 and 34-9-19).

Personal Information

Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Employee Information

School/Department: _____ Position: _____

Days Worked (circle one) : 10 month 11 month 12 month Hours worked per day: _____

Accident Information

Date of accident: _____ Time of accident: _____ Date notified supervisor: _____

Location of accident: _____

Describe how the accident occurred, what employee was doing, and specific injured body part:

Medical Treatment

Did you receive any type of first aid at your school/department? Y or N

Did you want to see a doctor? Y or N. If so, which doctor? _____



SUPERVISOR REPORT (JOB INJURY & VEHICLE ACCIDENTS)

Completion of this report is required for all work-related injuries/illnesses. The supervisor is responsible for conducting a preliminary investigation, completing this form, and submitting it to our Workers' Compensation Specialist, Mrs. Curlisha Mays, at mayscu@boe.richmond.k12.ga.us.

Employee Information

Employee Name: _____ Position: _____

Work Location: _____

Injury Information

Date of Injury: _____ Time of injury: _____ Date notified supervisor: _____

What task was the employee performing when injury occurred? _____

How did the injury occur (describe in detail): _____

Body part(s) injured: _____ Witnesses: _____

Was the employee acting in the course of employment (circle one): Yes No Unsure

Did the employee receive medical treatment (circle one): Yes No Unsure

Preventive Measures

Was the incident discussed with the employee (circle one)? Yes No

How could this injury be prevented in the future? _____



UNSAFE ACTS & UNSAFE CONDITIONS REVIEW

Vehicle Safety Violations Review (circle all that apply)

Weather Conditions	Wearing Seatbelt	Talking on phone/radio
Distracted	Speeding	Parked Illegally
Road Conditions	Improper use of mirrors	Traffic Laws
Lighting/Visibility	Other:	

Unsafe Workplace Conditions (circle all that apply)

Unguarded Hazard	Defective Safety Device	Defective Equipment
Hazardous Workstation	Unsafe Lighting	Unsafe Ventilation
Insufficient Training	Slippery or Uneven Surfaces	Blocked Egress
Other:		

Unsafe Acts by Employee (circle all that apply)

Improper Lifting or Material Handling	Failure to Follow Safety Protocols	Unauthorized Task
Did not ask for assistance	Using Defective Equipment	Misuse of Equipment
Horseplaying	Working While Distracted	Taking shortcuts
Improper Body Positioning or Posture	Ignoring Hazards	Improper Use of PPE
Other:		

Why did the unsafe conditions exist or act occur? _____

Were the unsafe acts or conditions reported prior to the incident (circle one)? Yes No

Have there been similar incidents prior to this one (circle one)? Yes No

Supervisor Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____



WORKERS' COMPENSATION ACKNOWLEDGMENT FORM

Workers' Compensation provides benefits to employees who sustain a work-related injury or illness arising out of and in the course of employment. Employees should refer to the Richmond County School System Employee Handbook for additional information regarding Workers' Compensation benefits and procedures.

Procedure

1. All work-related accidents, injuries, or illnesses must be reported immediately. Failure to report promptly may result in delayed or denied benefits. If a claim is investigated and determined to be non-compensable, the employee may be responsible for any medical expenses incurred.
2. Employees requiring medical treatment must obtain prior authorization by contacting Human Resources at 706-826-1000 ext. 5165. If the injury is not life-threatening, treatment must be obtained through a physician's office listed on the Panel of Physicians. Emergency Room visits are not considered a physician's office visit unless the injury is life-threatening.
3. Emergency clinics, the Veterans Administration Medical Center, and Eisenhower Medical Center are not authorized facilities for Workers' Compensation treatment unless prior authorization is granted.
4. If medical attention is needed, the employee must select a physician from the Panel of Physicians posted at the work location and listed on the Employee's Bill of Rights. An authorized school or department representative must schedule the initial medical appointment.
5. The Employee Accident Report, Employer Notification for Treatment of a Work-Related Injury, and Workers' Compensation Acknowledgement forms must be completed when filing a Workers' Compensation claim. These forms are available from the school nurse, school secretary, bookkeeper, principal/director, and on the district website at www.rcboe.org.
6. Absences due to a work-related injury or illness do not count toward retirement service credit. Workers' Compensation benefits do not include retirement contributions. Vacation and sick leave will not accrue during an approved Workers' Compensation absence.

Fraud Warning

Any person who knowingly and with intent to injure, defraud, or deceive any employer, employee, insurance company, or self-insured program files a statement of claim containing false or misleading information is guilty of a felony.

Acknowledgment

I hereby certify that I have received and reviewed the above Workers' Compensation information and acknowledge my understanding and agreement.

Employee Name (Print): _____ Date: _____

Signature: _____ SSN# _____



WITNESS STATEMENT FORM

Identifying Information

Name: _____ Name of Injured Employee: _____

Date of Incident: _____ Time of Incident: _____

What were you doing at the time of the incident?

How and when did you become aware of the incident?

What did you hear and see at the time of the incident?

Who else was present?

Please provide any additional information related to the incident.

Witness Signature: _____ Date: _____



EMPLOYER AUTHORIZATION FOR TREATMENT – WORK-RELATED INJURY

- A copy of this form must be presented in person to any selected Workers' Compensation medical provider to receive medical care.
- Please fax this form, the Employee Accident Report Form, and any supporting documentation to Workers' Compensation at (912) 355-8929.

Employee Name: _____

Date of Birth: _____

Employee Phone Number: _____

Employee Work Location: _____

Date of Injury: _____

Description of Injury: _____

Body Part Injured: _____

Authorized Workers' Compensation Physician: _____

Supervisor Signature: _____ Date: _____

Supervisor Contact Information (phone & email): _____