Cartersville City Schools

Employee Work Related Accident/Incident Packet

Contents Overview and Receipt Acknowledgment

******Employee Must Review and Sign ******

This package contains:

- Employee guidelines for accidents and reporting
- The employee work related accident/related injury report
- Witness Statement
- Official notice/ approved panel of physicians
- The employee election of workers' compensation benefits election form
- State of Georgia Board of Workers' Compensation Form WC- 207 (medical release form)
- The State of Georgia Workers' Compensation Bill of Rights for the injured worker
- Workers' compensation accident checklist

Receipt Acknowledgement

******Employee Must Sign******

- By signing this form, you are acknowledging receipt of this packet. You acknowledge that you will return this letter, along with the employee accident/injury report, the employee election of workers compensation benefits form, and the WC-207 form to the workers compensation contact no later than three (3) days of the reported accident.

Employee Name: _____

Employee Signature: _____

Date: _____

Date of Injury: _____

Employee Number: _____

Post Incident Information

If a work-related injury occurs, you must:

- In case of a life-threatening emergency/injury, call 911 or seek medical attention immediately.
- Report the incident/accident immediately to the school nurse and/or your supervisor, no matter how minor.
- Complete an employee accident report and benefit election form no later than 3 days from the date of your accident and return it to your Principal/Supervisor. Delay in notification could result in denial of payment for any medical services rendered.
- If the injury requires medical attention, you must select a physician from our approved 'Panel of Physicians' and notify the school nurse and the workers 'compensation contact. The 'Panel of Physicians' and a 'Bill of Rights is posted at each Cartersville City Schools facility.
- In the event of an afterhours incident/injury the employee should contact their immediate supervisor. The supervisor will contact the Workers Compensation contact or Human Resources representative to authorize after hours treatment from an approved panel physician..
- In case of an emergency, you may seek medical treatment from an emergency facility until the immediate emergency is over. However, a physician from the 'Panel of Physicians' must provide any additional medical treatment you receive.
- If you miss work as a result of a compensable injury, you may be entitled to receive pay for your lost time. This will be dictated by the Benefit Election form you completed with the accident report.
- If you elect to receive workers' compensation pay in lieu of your regular qualified leave pay (sick leave, vacation leave, etc.), it is your responsibility to arrange payment of benefits and payment of any other deductions while on leave. Please contact the workers compensation contact at 770-382-5880. You must also contact payroll while on leave and prior to your return as your yearly salary and/or scheduled deductions could be affected.

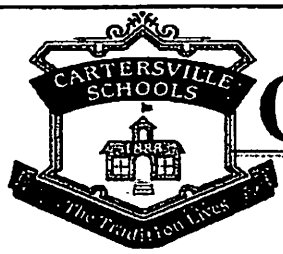
Reporting Guidelines

The employee COMPLETES the following, and gives to their Supervisor:

- Employee work related accident/incident report
- Employee election of workers' compensation benefits
- WC 207 (medical release form)

The employee KEEPS the following:

- Employee guidelines for workers' compensation accident reporting
- The Bill of Rights for the injured worker
- The official notice/panel of physicians



Cartersville School System

P.O. BOX 3310, 15 NELSON STREET, CARTERSVILLE, GA 30120

WORKERS' COMPENSATION ACCIDENT FORM

SECTION 1

FORM COMPLETION DATE: _____

EMPLOYEE NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____

JOB TITLE: _____

SECTION 2

DATE AND TIME INJURY OCCURRED: _____

LOCATION WHERE INJURY OCCURRED: _____

DESCRIPTION OF HOW ACCIDENT HAPPENED: _____

DETAILS OF INJURY: _____

PREVIOUS INJURIES OR SURGERIES: _____

NAME OF WITNESS(S): _____

SECTION 3

TREATING LOCATION/PHYSICIAN: _____

DATE & TIME: _____

NURSE'S SIGNATURE: _____ **DATE:** _____

Please complete this form and mail to the Summit Claims Center at PO Box 600, Gainesville, GA 30503-0600.

GEORGIA

INJURY STATEMENT IN YOUR OWN WORDS

Name			Married or single
Address		Telephone	
Email address	Occupation		Average weekly wage
Employer's name and address			
Date of birth	Social Security number		
Names and ages of dependents			
Date of accident	Time AM ☐ PM ☐	Place of accident	
Describe in detail what you were doing and what happened when the accident occurred.			
Continue on separate sheet, if necessary.			
Describe your injury.			
Names of witnesses or person(s) having knowledge of accident			
Name and address of attending physician			
Date of first visit	If seen by another physician(s), list the physician(s) name(s) and address(es)		
If still receiving treatment, how often do you visit your physician?		Did you lose time from work because of your injury? Yes ☐ No ☐	
Last day worked	Have you returned to work? Yes ☐ No ☐	If so, what date?	At what wage?
If still disabled, state present condition		When do you expect to return to work?	
Have you ever had a previous injury resulting in permanent or partial disability? If so, describe.			
Continue on separate sheet, if necessary.			

Date _____ Signed _____
(Signature of injured person)

summit®
...the *people* who *know* workers' comp®

Member of Great American Insurance Group

1-800-282-7644 | summitholdings.com

Cartersville City Schools

Witness Statement for Work Related Injury

Name of Injured Employee: _____

Your Name: _____ Phone Number: _____

Address: _____

Work Location: _____

How long have you known the injured employee: _____ Circle One: Weeks Months Years

When did you first become aware of the injury to the employee? Date: _____ Time: _____

Did you see the accident occur: YES NO

If yes, please describe: _____

_____

What did the injured employee say to you concerning the accident:

_____

_____

What part of the body was injured? (Right hand, knee, etc.)

_____

_____

What was the employee doing at the time of the accident?

_____

_____

_____

Was the accident reported? _____ If so, to whom? _____

List all the witnesses to the accident:

_____

_____

Witness Signature: _____ Date: _____

Cartersville City Schools
15 Nelson St
Cartersville, GA. 30120-2655

(This notice must be posted in a conspicuous place readily accessible to the employees at all times.)

PANEL OF PHYSICIANS

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

The insurance company providing coverage for this business under the Workers' Compensation Law is:

Insurer Name: Bridgefield Casualty Insurance Company Phone: 1-800-863-2181

Address: P.O. Box 600 Gainesville, GA 30503-0600

Insurer Email: summitproviderupdates@summitholdings.com

Instructions to injured worker: Review the following physician's contact information and select the provider with whom you would like to receive medical treatment.

Physician's Contact Information: Name, Address, Phone, and website listed below:

1. Urgent Care Center, Peachtree Immediate Care
   122 N Morningside Dr , Cartersville, GA 30121-2912
   (678)723-6721. Approximate mileage to Provider .3
2. Urgent Care Center, Piedmont Urgent Care
   11 Charley Harper Dr SE , Cartersville, GA 30120-1122
   (678)719-0087. Approximate mileage to Provider 2.1
3. Internal Medicine, David Kim, David E. Kim, MD, PC
   491 E Main St , Cartersville, GA 30121-3353
   (770)387-4512. Approximate mileage to Provider .4
4. Orthopaedic Surgery, Thad Riddle, Georgia Bone & Joint Surgeons
   15 Medical Dr NE Ste 101 , Cartersville, GA 30121-8005
   (770)386-5221. Approximate mileage to Provider 2.1
5. Orthopaedic Surgery, Gregory Crawley, Georgia Orthopedic Specialists
   5 Medical Dr NE , Cartersville, GA 30121-8003
   (770)386-8604. Approximate mileage to Provider 2.2
6. Orthopaedic Surgery, Steven King, Advent Health Group Orthopedics & Sports Medicine
   400 Timms Rd NE , Calhoun, GA 30701-7016
   (706)602-3100. Approximate mileage to Provider 24.7
7. General Surgery, Mark Wyatt, WellStar Medical Group Atlanta General Surgery
   1700 Hospital South Dr Ste 202 , Austell, GA 30106-8116
   (770)944-7818. Approximate mileage to Provider 24.3
8. Ophthalmology, Denise Johnson, Marietta Eye Clinic PA
   4450 Calibre Xing NW Ste 1104 , Acworth, GA 30101-4104
   (678)279-1141. Approximate mileage to Provider 8.4

(Additional doctors may be added on a separate sheet)

☐ This box is checked if additional physicians are listed on separate sheet.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19)

WC-P1 (7/2023)

06-05-24

Cartersville City Schools
15 Nelson St
Cartersville, GA 30120-2855

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

PANEL DE DOCTORES

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los limites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 dias (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clinicas indústriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un tambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

Nombre de la compañía de seguranza: Bridgefield Casualty Insurance Company Telefono: 1-800-863-2181

Direccion: P.O. Box 600 Gainesville, GA 30503-0600

Correo electronico: summitproviderupdates@summitholdings.com

Instruccions para el trabajador lesionado: Por favor de revisar la informacion de contacto de los sigientes proveedores medicos y seleccionar el proveedor de quien quiere recibir tratamiento medico.

Informacion de contacto del proveedor medico: Nombre, direccion, telefono, y sitio web enumerados a continuacion abajo:

1. Urgent Care Center, Peachtree Immediate Care
   122 N Morningside Dr , Cartersville, GA 30121-2912
   (678)723-6721, Approximate mileage to Provider .3
2. Urgent Care Center, Piedmont Urgent Care
   11 Charley Harper Dr SE , Cartersville, GA 30120-1122
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   (770)387-4512, Approximate mileage to Provider .4
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5. Orthopaedic Surgery, Gregory Crawley, Georgia Orthopedic Specialists
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   (770)386-8604, Approximate mileage to Provider 2.2
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   (706)602-3100, Approximate mileage to Provider 24.7
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8. Ophthalmology, Denise Johnson, Marietta Eye Clinic PA
   4450 Calibre Xing NW Ste 1104 , Acworth, GA 30101-4104
   (678)279-1141, Approximate mileage to Provider 8.4

(Proveedores medicos adicionales se pueden agregar en pagina adicional)

☐ Este cuadro es marcado si es que proveedores medicos adicionales son enumerados en pagina adicional.

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA SITIO WEB: https://www.sbwc.georgia.gov

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPOSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA 10.000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19)

WC-P1 (7/2023)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.

2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.

3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.

4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.

5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.

6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $533.33 per week, not to exceed 350 weeks.

7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $533.33 per week for no longer than 350 weeks.

8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $800 per week. A widowed spouse with no children will be paid a maximum of $320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.

2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.

3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.

5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.

6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.

7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.

8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.

10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.

11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.

12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.

2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.

3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que pueda tener derecho a beneficios médicos de por vida.

4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.

5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $800 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.

6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de $800 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $533.33 por semana, que no excedan 350 semanas.

7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de $533.33 por semana pero no más de 350 semanas.

8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $800 por semana. Una esposa viuda sin niños se le pagara un máximo de $320,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.

9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.

2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.

3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.

4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.

5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.

6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.

7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenía cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.

8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.

9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.

10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.

11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.

12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios— cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: https://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-334-6865.

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested.

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
Date of Injury	Birthdate	

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

_____

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(l) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

Benefits Election

Under the provisions of the Georgia Workers' Compensation Act, an employee who is disabled in a work-related accident may be entitled to Workers' Compensation benefits equal to two-thirds (2/3) of the employee's average weekly wage, not to exceed the current maximum weekly benefit of $800. These benefits commence after a 7-day waiting period. Compensation for the 7-day waiting period becomes payable only if the employee is disabled from work for 21 consecutive days. Instead of receiving weekly benefits, an employee may elect to receive full salary if the employee has sufficient Sick Leave or Vacation Leave to cover such an absence.

Please check the box of your choice below:

- o I elect to use my Sick Leave for the duration of the work-related injury. If all sick leave is used before returning to work, Workers' Compensation benefits will pay for the remaining period of disability (sick leave will be deducted from the employees sick leave bank).

- o I elect to use my accrued Vacation Leave in lieu of Workers' Compensation benefits for lost time. If all Vacation leave is used before returning to work, Workers' Compensation benefits will pay for the remaining period of disability.

- o I elect to be on Leave Without Pay until Workers' Compensation benefits begin on the eighth (8) calendar day.

- o I elect to use _____ days of Sick Leave (list dates _____). If I am still disabled and unable to work after this time, I wish to start receiving benefits according to the Workers' Compensation Guidelines as set for by the State of Georgia.

- o I elect to receive compensation according to the Workers' Compensation Guidelines as set forth by the State of Georgia.

Employee Authorization

Note: In electing to use Sick Leave in lieu of Workers' Compensation, the employee agrees to return any Workers' Compensation monies that are received covering the same period of time that has already been paid by Sick Leave.

If still employed by Cartersville City Schools, the employee's signature herewith authorizes the school system to withhold this amount from future earnings.

Employees Name: _____

Employees Signature: _____ Employee Number: _____

Declination of Medical Treatment for Work Related Injury

I have reported an injury to my employer that may be work related. Medical treatment has been offered but I voluntarily decline.

I understand that if I experience symptoms that indicate a need for medical evaluation, I must immediately inform my supervisor and/or school nurse and choose a physician form the approved Cartersville City Schools designated physician panel. Arrangements will be made for me to be treated.

I have been provided with an employee accident/incident information packet and have been directed to the Cartersville City Schools panel of physicians.

I, _____ willingly decline treatment for a possible work-related injury sustained on _____ (date).

Signature: _____

Date: _____

Administrator: _____

Date: _____

Witness: _____

Date: _____

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

Express Scripts

ID#: ______________________

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: ____ / ____ / ____
MM/DD/YYYY

Group #: G69A

Employee Date of Birth: ____ / ____ / ____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

______________ ______ ______________
First M Last

____
Street Address or PO Box

______________ ______________ ______
City State ZIP

Employer Name

____

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

Post Incident Checklist:

- Completed the Employee Accident/Incident Report truthfully, and informed the school nurse and/or supervisor of any potentially hazardous conditions?
- Selected a provider form the approved panel of physicians?
- Completed the Employee Election of Workers Compensation Benefits form?
- Completed the WC-207 (Medical Release Form)?
- Checked the injury packet for correct legal name, address, and phone number?
- Kept the Employee Guidelines for Workers Compensation Accidents?
- Kept the Bill of Rights for the Injured Worker?