

Workers Compensation Claim File

Facility: Coffee County Board of Education

Employee Name: _____

Date of Accident: _____

School Checklist

In an emergency situation, getting the employee to the emergency room and stabilized is the first priority.

I. Before sending employee to the Physician:

To Report an Injury or Claim - Do Things Immediately

- Call EWC Claims Handling at 1-888-590-9487.
- Complete and Fax **Form WC-1** First Report of Injury to Sylvia Carr at 383-5483.
- Complete **Authorization for Medical Treatment through Identity MCO Acknowledgement Form**; give a copy with an attached **Prescription Card** to employee. The employee will take these forms to the doctor they attend. (If the employee refuses medical care, see next item)
- If the employee refuses medical treatment, complete the **Acknowledged Refusal of Medical Treatment Form**

**Claims Reported after 72 Hours raise cost by 40%. Please report all injuries in the same day, even same hour, so we can manage the injury and claim. It benefits everyone.*

II. After the employee has received medical attention:

- Collect any Physician Notes and send to Sylvia Carr.
- Send any medical bills for the employee and send to Sylvia Carr.
- Complete the **Accident Investigation Report**
- Complete the **Witness Statement Injury/Accident Investigation Report**

Board Claim No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY

A. IDENTIFYING INFORMATION						
EMPLOYEE		Last Name		First Name		M.I. <input type="checkbox"/> Male <input type="checkbox"/> Female
Address		Phone Number		Social Security Number		
Employee E-mail		NAICS Code		Nature of Business (Trade, Transport, Mfg., etc.)		
EMPLOYER		Name Coffee County Board of Ed.		Phone Number 912-384-2086		Date of Birth 58-6000215
Address P. O. Drawer 1290 Douglas, GA 31534		Accident Location		Employer E-mail		
INSURER / SELF-INSURER		Name SEUS		Claims Office Address P. O. Box 191387 Atlanta, Ga. 31119-1387		
CLAIMS OFFICE		Name Common Sense Claims, Inc. (CSC)		Claims Office Phone 888-590-9487		
SBWC ID # (five digit no.)		Insurer/ Self-insurer File #		Claims Office E-mail		
EMPLOYMENT/WAGE		Date Hired by Employer		Job Classified Code No.		Number of Days Worked Per Week
List Normally Scheduled Days Off						Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month
INJURY/ILLNESS & MEDICAL		Date of Injury		Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm		County of Injury
Date Employer Notified		Enter First Date Employee Failed to Work a Full Day		Body Part Affected		
Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Injury/Illness		
If Returned to Work, Give Date		Returned at what wage per Week		If Fatal, Enter Complete Date of Death		How injury or illness / Abnormal Health Condition Occurred
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs		Hospital / Treating Facility (Name and Address)		
Report Prepared By (Print or Type)				Telephone Number		Date of Report
B. INCOME BENEFITS						
Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No		Average Weekly Wage: \$ _____		Weekly benefit: \$ _____		Date of disability: _____
Form WC-6 must be filed if weekly benefit is less than maximum						
Date of first Payment: _____		Compensation paid: \$ _____		or Date salary paid: _____		Penalty paid: \$ _____
BENEFITS ARE PAYABLE FROM _____ FOR:						
<input type="checkbox"/> Temporary total disability		<input type="checkbox"/> Temporary partial disability		<input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.		
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.						
C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION						
Previously Medical Only? <input type="checkbox"/> Yes <input type="checkbox"/> No		Benefits will not be paid because:				
D. MEDICAL ONLY INJURY <input type="checkbox"/> No disability paid or controverted						
(Insurer / Self-insurer: Type or Print Name of Person Filing Form)				Signature		Date
Phone and Ext.		E-mail				

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-556-3818 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. 134-9-18 AND 134-9-19).

FORM WC-1

REVISION . 07/2005

1

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682

In Atlanta: (404) 656-3818

<http://www.sbwg.georgia.gov>

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.sbwg.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. 134-9-18 AND 134-9-19).

**AUTHORIZATION FOR
MEDICAL TREATMENT FOR
WORKERS' COMPENSATION
THROUGH IDENTITY MCO, INC.**

**DRUG SCREEN/BLOOD ALCOHOL
MUST BE PERFORMED
FOR ALL WORK COMP INJURIES**

PROVIDER: SOUTHEASTERN US CAPTIVE INSURANCE, INC.

COMPANY NAME: Coffee County Board of Education

EMPLOYEE NAME: _____

DATE OF INJURY: _____

TYPE OF INJURY: _____

BILL TO: Identity MCO, Inc.
C/O Common Sense Claims, Inc., TPA
P.O. Box 191387
Atlanta, GA 31119

SIGNATURE OF SUPERVISOR

DATE

ACKNOWLEDGED REFUSAL OF MEDICAL TREATMENT

I, _____, hereby state that on _____
(Your Name) (Date)

I, _____
(Description of Incident)

I have reported an injury, have reviewed the Employee Manual pertaining to the treatment by our MCO physicians, have been offered medical treatment, but have refused that medical treatment. I understand that in the future if I seek medical treatment, it will be necessary for me to follow the procedures set out in the Employee Manual pertaining to the treatment by our MCO physicians.

I further understand that I am required to undergo a post accident drug/alcohol test at the time of the reporting of the above incident.

I missed less than 4 hours from work. Yes No

I returned to regular work on _____ / _____ / _____
Day Month Year

Employee Signature Print Name Date

Supervisor Signature Print Name Date

A-CHECKLIST: Accident Investigation

When you're involved in an accident and the investigation effort, the details you provide will be important in determining what happened and to give clues for avoiding future incidents. The information that you record should focus on the: **who, what, when, where, how** and **why** facts of the accident. This list of sample questions needs to be addressed during the investigation and will help you document many aspects of the accident scene.

Who

Was involved in the accident?
Was injured?
Witnessed the accident?
Reported the accident?
Notified emergency medical services personnel?

What...

Company property was damaged?
Evidence was found?
Was done to secure the accident scene?
Was done to prevent the recurrence of the accident?
Level of medical care did the victims require?
Was being done at the time of the accident?
Tools were being used?
Was the employee told to do?
Machine was involved?
Operation was being performed?
Instructions had been given?
Precautions were necessary?
Protective equipment should have been used?
Did others do to contribute to the accident?
Did any witnesses see?
Safety rules were violated?
Safety rules were lacking?
New safety rules or procedures are needed?

When...

Did the accident happen?
Was it discovered?
Was the accident reported?

Did the employee begin the task?
Were hazards pointed out to employee?
Did supervisor check employee progress?

Where...

Did the accident happen?
Was employee's supervisor when accident occurred?
Were witnesses when accident occurred?
Does this condition exist elsewhere on site?
Is the evidence of investigation to be kept?

How...

Did the accident happen?
Was the accident discovered?
Were employees injured?
Was equipment damaged?
Could the accident have been avoided?
Could the supervisor have prevented the accident from happening?
Could co-workers avoid similar accidents?

Why...

Did the accident happen?
Were employees injured?
Did the employee behave that way?
Wasn't protective equipment used?
Weren't specific instructions given?
Was the employee in that specific place or position?
Was the employee using that machine or specific tool?
Didn't employee check with supervisor?
Wasn't the supervisor there at the time?

ACCIDENT INVESTIGATION REPORT

This form is for reporting to management and may be submitted to the Insurance Company if petitioned to do so.

WHO WAS INJURED?	NAME _____ OCCUPATION _____ DEPARTMENT _____								
TIME AND PLACE	DATE _____ TIME _____ EXACT LOCATION _____ _____								
DESCRIBE INJURY	_____ _____								
A DETAIL ACTIONS PRIOR AND UP TO INJURY. WHAT HAPPENED? USE REVERSE SIDE TO EXTEND COMMENTS	_____ _____ _____ _____ _____								
B WHAT UNSAFE CONDITION (S) OR ACT (S) CAUSED THIS ACCIDENT?	_____ _____ _____								
HOW CAN SIMILAR ACCIDENTS BE AVOIDED?	_____ _____ _____								
WHAT ACTION HAVE YOU TAKEN TO PREVENT SIMILAR ACCIDENTS?	_____ _____ _____								
 <table border="0" data-bbox="277 1742 1516 1881"><tr><td>_____</td><td>NAME-POSITION</td><td>_____</td><td>DATE</td></tr><tr><td>_____</td><td>NAME-POSITION</td><td>_____</td><td>DATE</td></tr></table> EMPLOYER'S FIRST REPORT OF INJURY SUBMITTED _____ DATE _____		_____	NAME-POSITION	_____	DATE	_____	NAME-POSITION	_____	DATE
_____	NAME-POSITION	_____	DATE						
_____	NAME-POSITION	_____	DATE						

B - ACCIDENT INVESTIGATION FORM

EMPLOYEE GUIDE

As soon as possible after an accident occurs, the investigation should be completed. Answer all questions in detail – give factual information.

The only way to prevent accidents is to FIND and REMOVE accident causes. There is always a cause for an accident, be it an unsafe condition, an unsafe act or a combination of both. Occasionally, the cause cannot be eliminated in a practical manner, but usually it can be controlled and a repeat avoided.

When completing the report form incorporate the “who, what, when, where, how & why” factors (attached page) as often as possible. Lastly, be clear on the 3 key elements of: 1) UNSAFE CONDITION 2) UNSAFE ACT 3) UNSAFE PERSONAL FACTOR. Below are examples of what is needed in these 3 critical areas of evaluation. These factors are not in themselves accident causes, they do however, prompt or cause many unsafe acts and contribute to the creation of many unsafe conditions.

THE UNSAFE CONDITION

Unguarded or inadequately guarded machinery, floor openings, etc.
Defective tools, ladders, etc.
Hazardous arrangement, procedure, etc. (unsafe storage, congestion, etc.)
Improper illumination (insufficient light, glare, etc.)
Improper ventilation (insufficient air change, impure air source, etc.)
Unsafe dress or apparel (absence of or defective gloves, aprons, shoes, respirators, etc.)

THE UNSAFE ACT

Operating without authority, failure to secure, failure to place warning signs, signals, tags, etc.
Operating or working at unsafe speed (too slow/fast, jumping from vehicles/platforms, throwing materials, etc.)
Making safety devices inoperative (removing, mis-adjusting, disconnecting, etc.)
Using unsafe equipment, hands instead of equipment, etc.
Unsafe loading or placing (overloading, crowding, arranging or placing objects/materials unsafely)
Taking unsafe position or posture (under suspended loads, lifting with bent back, exposed to falling or sliding objects, riding in unsafe position, riding on apparatus designed only for materials)
Working on moving or dangerous equipment (cleaning, adjusting, oiling etc.)
Distracting, teasing abusing, startling, etc. (quarreling, horseplay, practical jokes, etc.)
Failure to use safe attire or personal protective equipment (goggles, safety shoes, masks, etc.)
Improper use of safety equipment or failure to use provided safety equipment

THE UNSAFE PERSONAL FACTOR

Improper attitude (disregard of instructions, rules and customs, showoff, defiant, etc.)
Lack of knowledge or skill (unaware of safe practice, unskilled, inexperienced, etc.)
Physical defects (fatigue, drugs/alcohol, unable to understand, excitable, nervous, visual/hearing)

WITNESS STATEMENT INJURY/ACCIDENT INVESTIGATION

INJURED EMPLOYEE _____ Date of Injury _____

NAME OF WITNESS _____ Department _____

Did you see accident happen? Yes No

Were you in the area where the accident happened? Yes No

Where exactly did the accident happen? _____

Explain what happened _____

Was it obvious that the employee was hurt? Yes No

What part of body was injured (be specific)? _____

Was the employee using a tool or machinery when injured? Yes No

Describe the equipment _____

Have you ever heard employee complain of similar injury or illness? Yes No

Have you ever heard the employee talk about on the job injury before? Yes No

Are you aware of any other accidents, personal or on-the-job, that
this employee has had? Yes No

If so, describe _____

Did the employee violate a known safety rule? Yes No

Did you know for a fact that employee was aware of safety rule? Yes No

Do you know if the employee was ever cautioned by supervisor or
anyone else about unsafe work habits? Yes No

What do you think caused the accident?

Unguarded equipment

Non-employee

Employee carelessness

Horseplay

Deliberate violation of safety rule

Poorly maintained equipment

Another employee

Pressure to work faster

What can be done to prevent a similar accident in the future? _____

To the best of my knowledge the above questions are answered truthfully.

Sworn to me this _____ day of _____ 20____.

Witness Signature

Supervisor Signature