



PROVISIONS



FOR



JOB-RELATED INJURIES



MADISON COUNTY SCHOOLS
TERRY L. DAVIS, ED.D., SUPERINTENDENT

Madison County Board Of Education

JOB-RELATED INJURY
INSTRUCTIONS to EMPLOYEES and SUPERVISORS
and
STATEMENT OF AWARENESS

In compliance with Board Policy **FILE: GBRI**, Absences Due to Job-Related Injuries, page 10 of 11, the following instructions must be followed when injuries occur on the job. Please read all instructions carefully and follow all that apply. All forms mentioned are included in this document.

A >>> INSTRUCTIONS FOR INJURED EMPLOYEE

1. Report the injury to immediate supervisor **within 24 hours** of incident and complete the following forms:
 - **INJURY REPORT**
 - **STATEMENT OF AWARENESS**
 - **GROUP/ASSOCIATION – PROOF OF LOSS**
 - **PHYSICIAN CERTIFICATION** (if injury requires medical attention)
Items 1-11 completed by **employee**; Items 12-16 completed by **physician**
 - **REQUEST FOR LEAVE DUE TO JOB-RELATED INJURY** (If injury requires absence of one-half (1/2) day or more)
2. *“Each and all absences beyond three (3) days must have a physician’s authorization to be absent due to the reported injury.”* The date listed in **Item 13** of **PHYSICIAN CERTIFICATION** form must be the same as the **DATE RETURNED TO WORK** on **REQUEST FOR LEAVE** form. Days absent beyond the date listed in Item 13 will require an **additional PHYSICIAN CERTIFICATION** form with the exact date for return to work specified in Item 13.

B >>> STATEMENT OF AWARENESS (To be signed by employee)

Until all forms are completed and the Board approves the requested leave, sick leave will be charged. If sick leave is not available, days without pay will be charged.

The Board of Education may exercise the option of requiring a second opinion from another physician concerning injuries.

Leave for job-related injuries may not exceed 90 days. Beyond the 90 days, benefits may be available through insurance carried by the Board of Education with the Insurance Company of North America (CIGNA companies).

Injury claims for further benefits, in addition to those provided by the Madison County Board of Education and CIGNA, will be handled by the Alabama State Board of Adjustment as authorized by the *Code of Alabama*, 1975, Section 49-9-62. Claimants have one (1) year from the date of cause of action to file a claim with the Board of Adjustment. A claim that is not filed with the Board of Adjustment within one (1) year from the date of the accident will not be accepted.

I, _____, am aware of the procedures for reporting job related injuries to my employer and of the one-year Statue of Limitations for filing an injury claim before the Alabama State Board of Adjustment.

Signature of Employee

C >>> INSTRUCTIONS FOR SUPERVISOR OF INJURED EMPLOYEE

1. Ensure proper forms are completed as per instructions above
2. Sign all forms where *Supervisor Signature* is required
3. Forward all forms (including this page) to the Personnel Office

Madison County Board Of Education

INJURY REPORT FOR JOB-RELATED INJURY

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)		2. Social Security Number ____ - ____ - ____	3. Date of Birth ____ / ____ / ____	4. Sex ___ M ___ F
5. Home Address (Number and Street) (City or Town) (State) (Zip)		6. Telephone Number Home () _____ Work () _____	7. Job Title	8. Status ___ Full Time ___ Part Time ___ Contract
9. School / Work Site		10. School / Work Site Address (Number and Street) (City or Town) (State) (Zip)		
11. Date of Injury ____ / ____ / ____	12. Time of Injury ____ : ____ a.m. ____ p.m.		13. Date Employer Notified ____ / ____ / ____	
14. Is employee covered by medical insurance ___ Yes ___ No If yes: ___ Blue Cross/Blue Shield ___ Other _____		15. Name and address of attending physician		
16. Name and address of medical facility where treated ___ Hospitalized ___ Outpatient ___ Emergency Treatment		17. Name of school / work site where injury occurred		
		18. Location or place where injury occurred		
19. Describe fully what happened to cause the injury or illness				
20. Describe the injury or illness in detail and indicate the body part(s) affected				
21. Were there any witnesses to the injury? ___ No ___ Yes (If "yes," give name, address, and telephone number)				
22. _____ Signature of Injured Person Print Name Daytime Telephone Number Date				
23. _____ Signature of Supervisor (or other designated authority) Print Name Daytime Telephone Number Date				
01/16/02				

**Group/Association - Proof of Loss
Medical Benefits**

Insurance Company of North America
Life Insurance Company of North America
INA Life Insurance Company of New York



Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any material false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

TO BE COMPLETED BY EMPLOYER/ADMINISTRATOR

NAME AND ADDRESS OF EMPLOYER/ASSOCIATION			POLICY NO.	
COVERAGE EVER TERMINATED (IF YES, GIVE REASON AND DATE OF TERMINATION) <input type="checkbox"/> Yes <input type="checkbox"/> No		CLAIMANT'S INSURANCE ISSUED ON THE BASIS OF STATEMENT OF PHYSICAL CONDITION <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE HIRED/MEMBER OF ASSOCIATION
ACCIDENT OR SICKNESS DUE TO EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No	CLAIMANT <input type="checkbox"/> Employee <input type="checkbox"/> Dependent	EFFECTIVE DATE	DIVISION OR CLASS	
AUTHORIZED REPRESENTATIVE				DEDUCTIBLE
				DATE SIGNED

TO BE COMPLETED BY EMPLOYEE/MEMBER

NAME OF EMPLOYEE/MEMBER (Last Name)		(First Name)		(M.I.)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
ADDRESS OF EMPLOYEE/MEMBER (Street)			(City)	(State)	(Zip)	EMPLOYEE'S SOC. SEC. NO.
NAME OF PATIENT				DATE OF BIRTH		RELATIONSHIP TO INSURED
PATIENT'S SOC. SEC. NO.	PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	PATIENT'S OCCUPATION				
IF CHILD, IS SHE/HE MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF CHILD, OLDER THAN 18? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, FULL-TIME STUDENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, NAME OF SCHOOL			
DESCRIPTION OF ACCIDENT OR ILLNESS					ACCIDENT OR ILLNESS DUE TO EMPLOYMENT <input type="checkbox"/> Yes <input type="checkbox"/> No	
DATE OF ACCIDENT OR BEGINNING OF ILLNESS		INJURY DUE TO AUTO ACCIDENT <input type="checkbox"/> Yes <input type="checkbox"/> No		HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS <input type="checkbox"/> Yes <input type="checkbox"/> No		
ARE YOU OR YOUR DEPENDENT COVERED UNDER ANOTHER INSURANCE PLAN, GOVERNMENT PLAN SUCH AS MEDICARE, AN HMO PLAN OR AUTOMOBILE MANDATORY NO-FAULT COVERAGE WHICH WILL ALSO COVER ANY OF THE MEDICAL EXPENSES OF THIS CLAIM? <input type="checkbox"/> Yes <input type="checkbox"/> No				IF YES, GIVE NAME OF INSURANCE COMPANY / FIRST BENEFIT INSURER, ORGANIZATION, OR HMO PROVIDING BENEFITS.		
NAME AND ADDRESS					POLICY NO.	

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to any CIGNA company, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

NAME OF PATIENT	SIGNATURE OF PATIENT (PARENT OR GUARDIAN IF CLAIM IS ON A MINOR)	DATE
PAYMENT AUTHORIZATION — I authorize payment directly to those physicians or providers described below, and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me.		IF YES, SIGNATURE OF EMPLOYEE/MEMBER
		DATE
I certify that the foregoing information is true and correct.		SIGNATURE OF EMPLOYEE/MEMBER
		DATE

TO BE COMPLETED BY THE PHYSICIAN OR PROVIDER

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY — RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR ICD-9 CODE.			DATE FIRST CONSULTED FOR THIS CONDITION	DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED
1. 2. 3. 4.			NAME AND ADDRESS OF REFERRING PHYSICIAN	
A. DATE OF SERVICE	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (Specify unusual services or circumstances)	D. ICD-9 DIAGNOSIS CODE	E. CHARGES
YOUR PATIENT'S ACCOUNT NUMBER		PHYSICIAN'S OR PROVIDER'S TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER TO BE USED FOR TAX REPORTING TAX ID #	PHYSICIAN'S OR PROVIDER'S NAME AND ADDRESS	
		SOC. SEC. #	TOTAL CHARGE	
			AMOUNT PAID	
		PHYSICIAN'S OR PROVIDER'S TELEPHONE NUMBER	BALANCE DUE	
I certify that the foregoing information is true and correct and that the charges are the actual charges to the insured.			PHYSICIAN'S OR PROVIDER'S SIGNATURE	
			DATE	

- * 1. (H) — Inpatient Hospital 3. (O) — Doctor's Office 5. (PSY) — Day Care Facility 7. (NH) — Nursing Home 9. Ambulance A. (L) — Independent Laboratory
 2. (OH) — Outpatient Hospital 4. (P) — Patient's Home 6. (PSY) — Night Care Facility 8. (SNF) — Skilled Nursing Facility C. (OL) — Other Locations B. Other Medical Facility

Madison County Board Of Education

**PHYSICIAN CERTIFICATION
FOR JOB-RELATED INJURY**

Items 1-11 to be completed by employee; Items 12-16 to be completed by attending physician

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number ____ - ____ - ____	3. Date of Birth ____ / ____ / ____	4. Sex ____ M ____ F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home () _____ Work () _____	7. Job Title	8. Status ____ Full Time ____ Part Time ____ Contract
9. School / Work Site	10. School / Work Site Address (Number and Street) (City or Town) (State) (Zip)		

11. Date of Injury ____ / ____ / ____	12. Is there reasonable expectations that the employee will be able to return to work? ____ Yes ____ No	13. If "yes " on Item 12, give the date or approximate date of return. ____ / ____ / ____
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14. If the employee can return to work, are there any restrictions on the employee's duties? ____ Yes ____ No
If "yes", how long will the restrictions apply?

15. If "no" on Item 12, give details regarding employee's inability to return to work.

16.

Signature of Attending Physician Print Name Daytime Telephone Number Date

Madison County Board Of Education

REQUEST FOR LEAVE DUE TO JOB-RELATED INJURY

TO BE COMPLETED IN THE EVENT A JOB-RELATED INJURY RESULTS IN ABSENCE FROM WORK FOR ONE-HALF (1/2) DAY OR MORE

IN ADDITION:

- Each and all absences beyond three (3) days must have a physician's authorization to be absent due to the reported injury. Attach PHYSICIAN CERTIFICATION FORM - Item 13 of PHYSICIAN CERTIFICATION form must match DATE RETURNED TO WORK on REQUEST FOR LEAVE form.
Days absent beyond the date listed in Item 13 of PHYSICIAN CERTIFICATION form will require an additional PHYSICIAN CERTIFICATION form and a new REQUEST FOR LEAVE form

NAME OF EMPLOYEE: Last First Middle

SOCIAL SECURITY NUMBER: - -

JOB SITE: WORK ASSIGNMENT:

LEAVE DAYS REQUESTED: DATE OF INJURY:

DATE(S) ABSENT FROM WORK:

DATE RETURNED TO WORK: Each and all absences beyond three (3) days must have a physician's authorization to be absent due to the reported injury. If applicable, attach PHYSICIAN CERTIFICATION FORM - Date specified in Item 13 of PHYSICIAN CERTIFICATION form must be the same as DATE RETURNED TO WORK on REQUEST FOR LEAVE form.

HAVE OTHER LEAVE REQUESTS BEEN SUBMITTED AS A RESULT OF THIS INJURY?

NO YES - NUMBER DAYS

Signature of Employee Date

Signature of Employee's Immediate Supervisor Date

Director of Personnel Approval for Board Action Date