HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION POLICY

The School Board provides Workers' Compensation insurance coverage at no cost to employees. This insurance program covers an injury (by accident) or illness (occupational disease) which arises out of and in the course of employment that requires medical, surgical, or hospital treatment.

Employees who are injured while performing their assigned work duties are required to notify their principal or supervisor immediately of the injury.

Please read the "Instructions to Employees Injured On the Job" reference guide.

If you have any questions regarding the procedures outlined, please contact Michele Little in Human Resources at 365-4688 or via email at mlittle@hcps.us.

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION

INSTRUCTIONS TO EMPLOYEES INJURED ON THE JOB

This form is intended as a quick reference for you following an injury/illness that may have happened at work. It does not contain all information regarding a work-related injury/illness.

SEVERE/LIFE THREATENING INJURY

SEEK MEDICAL TREATMENT IMMEDIATELY. If possible, notify supervisor by phone and complete worker's compensation paperwork as soon as possible.

NON-LIFE THREATENING INJURY

Following an Injury on the Job

1. Report to your supervisor that you have had an injury on the job. Your supervisor is required to file an injury report following the incident. He/she may need to obtain information from you and any witnesses about the incident. You will be asked to complete an **Employee Accident Report** *(Your supervisor may complete this for you if you are unable due to your injury)*. You will also be given an **Approved Panel of Physicians** in the event you need to seek medical treatment. You may select a physician from the **Initial Visit Panel of Physicians** or go to an Emergency Facility, provided a panel physician is unavailable, the injury is a true emergency or permission is received from a physician. You will also be asked to sign an **Acknowledgement of Panel of Physicians** form. **These forms should be completed and sent to HR as soon as possible.**

2. If you decide to seek medical treatment, please take the **Physical Capabilities Form** with you and ask your physician to complete the form indicating your diagnosis and work status. *A physician report may be submitted in lieu of this document.*

3. Give your completed paperwork to your supervisor along with the **Supervisor's Incident Analysis Report** and **Statement of Employee's Work Status** forms for your supervisor's completion.

Following Initial Medical Treatment

1. **You are returned to work without restriction –** Return to your supervisor with the **Physical Capabilities Form** stating that you are returned to work without restrictions – full duty.

2. **You are returned to work with restrictions** – Return the physician completed **Physical Capabilities Form and RTW Medical Certification Form to the HCPS HR Office** stating the specific restrictions – light duty. HCPS HR staff will determine if the restrictions can be accommodated. If the restrictions cannot be accommodated, you may be out of work with the approval of your supervisor. **You are responsible for keeping your supervisor and HCPS HR informed of your work status and keeping any follow-up appointments regarding your restrictions. Follow-up appointments must be made at least every 4 weeks to provide an updated work status.** Appointments should be made outside of your normal work hours if possible. If this is not possible, your supervisor must be informed of the appointment. Medical treatment visits should be charged as workers' compensation leave up to a maximum of 4 hours per visit.

3. **You are NOT able to return to work** - Submit the physician completed **Physical Capabilities Form and RTW Medical Certification Form** as soon as possible to the HCPS HR Office or ask the physician to fax this information directly to Judith Marston, HCPS HR. These forms must include a diagnosis, prognosis and specific information about your medically necessary inability to perform your job and dates you cannot work. **It is the EMPLOYEE'S responsibility to have the physician complete these forms and to return them to HCPS HR** so the lost time can be coded as workers' compensation.
   - **a.** Your lost time will be coded as workers' compensation leave until your claim is either approved or denied by the school system's insurance carrier. Please see "Claim Denial" below for the handling of lost time if your claim is denied.
   - **b**. Workers' Compensation absences run concurrently with FML or a medical leave of absence. Contact Michele Little in Human Resources at **365-4688** to initiate the forms required for job protected coverage if you are out of work for medical reasons.

c. You are responsible for keeping your supervisor informed of your work status and keeping any follow-up appointments regarding your disability. **When returning from a disability, you must have a completed HCPS Return to Work Medical Certification Form** or something similar and specific from the treating physician.

Medical Treatment Beyond Initial Medical Treatment

Treatment beyond the initial medical evaluation may be with a physician approved by the HCPS insurance carrier. If the physician is not listed on the Approved Panel of Physicians, please contact Michele Little for approval. Orthopedic specialists are listed on the Approved Panel of Physicians.

1. Let the provider know that you are being treated for an injury/illness that happened at work. If they are not familiar with our HCPS insurance carrier information (Sedgwick), please ask them to contact Michele Little for billing and claim information.

2. Once the physician has determined any treatment beyond the initial office visit (i.e. physical therapy, MRI, injections, etc.) please have the physician contact the HCPS insurance carrier for approval prior to scheduling any treatment. Send copies of all forms/documents related to the accident to **Michele Little at the School Board Office or FAX to 804-365-4583**.

3. You should not be charged for any medical treatment or co-pay.

4. Appointments should be made outside of your normal work hours if possible. If this is not possible, your supervisor must be informed of the appointment. Medical treatment visits should be charged as workers' compensation leave up to a maximum of 4 hours per visit.

Wage Replacement for Time Lost

While an employee is out of work on workers' compensation leave, wages will be paid at 100% of the employee's regular earnings for a maximum period of 90 days.

If the employee is unable to return to work after 90 days, the HCPS insurance carrier (Sedgwick) will begin compensating the employee directly at 66.6% of the employee's regular earnings on the 91st day. These wages are not subject to tax withholdings.

Claim Denial

If you fail to provide adequate information on your accident report or do not provide updates on medically necessary appointment and treatment to HCPS HR, your claim may be denied by our workers' compensation carrier (Sedgwick), and, in that case, you will be responsible for payment of all medical invoices unless notified otherwise. You will need to notify your physician of the denial and provide your personal insurance information.

If you are currently working under a work restriction, you will be out of work until you are able to return to full duty. Light duty work is usually not available.

If you have had lost time, you will be required to pay back time/monies received from the school system while on workers' compensation leave. If you have appropriate leave balances (i.e. sick, vacation or personal leave) an adjustment will be made by the Payroll Dept. to cover the time charged to workers' compensation leave. Should limited or no leave balances be available, arrangements with the Payroll Dept. should be made to reimburse wages paid that are not covered by leave balances.

Contact Information

Human Resources	**Michele Little** **(804) 365-4688** **(804) 365-4583 FAX** **mlittle@hcps.us**
HCPS Workers' Compensation Insurance Carrier	Sedgwick/CMS P. O. Box 14663 Lexington, KY 40512-4663 (804) 673-5900 (804) 673-5400 FAX

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION
APPROVED PANEL PHYSICIANS

IF INJURED AT WORK YOU MUST:

- Report the incident IMMEDIATELY to your **principal or supervisor**. Complete an **Employee Accident Report.**

- **If medical treatment is needed, you must choose a physician from the INITIAL VISIT PANEL OF PHYSICIANS listed below.** Your principal/supervisor will give you a **Physical Capabilities Form** to take to the approved physician for completion.

- If an Initial Visit Panel Physician is unavailable at the time of an emergency, an emergency facility's physician may treat you only at that particular time. The physician chosen by you from the Panel must conduct any and all follow-up that is necessary due to your injury. Your Panel Physician will refer you to one of the specialists listed below or another physician approved by our Workers' Compensation Carrier if needed. ***You may not go to a specialist without first being referred by a panel physician. All specialists MUST BE approved by our Worker's Compensation carrier.***

- As Virginia Law requires, (Section 65.1-88), below is listed the Panel of Physicians from whom you must choose a treating physician. If you do not receive treatment from a Panel Physician, your Workers' Compensation benefits may be terminated and your medical bills may not be paid by the Workers' Compensation Carrier. There is no charge to you for medical bills incurred for care received by a Panel Physician in cases where the carrier accepts the claim as compensable. If you are injured at work, your Workers' Compensation Insurance will only be responsible for bills from the following:

    1. Initial Visit Panel Physician;
    2. Emergency Facility, provided the injury is a true emergency or permission is received from a Panel Physician;
    3. Specialist to whom you are referred by a Panel Physician or by the Workers' Compensation Insurance Carrier.

IMPORTANT NOTE:
Services for injuries or diseases related to your job, which are compensable under the Virginia Workers' Compensation Act, are excluded from coverage under your health insurance, unless the claim is denied Workers' Compensation.

INITIAL VISIT WORKERS' COMPENSATION PANEL OF PHYSICIANS:

The physician listed is the preferred provider but you may see other physicians at these facilities.

Bon Secours Good Health Express **Dr. A. Thurman** 8200 Meadownbridge Rd. Suite 301 Glen Allen, VA 23059 **(804) 442-3705**	**Hanover Family Physicians** **Dr. L. Blackburn, Jr.** **Dr. M. Petrizzi** **Dr. Micah Houghton** 9376 Atlee Station Rd **&** **(804) 730-0990**	**Patient First – Short Pump Dr.** **Dr. E. Bigelow** 370 Pump Road Henrico, VA 23233 **(804) 360-8061**	**Patient First – Mechanicsville** **Dr. M. Aquilo** 7238 Mechanicsville Tnpk Mechanicsville, VA 23111 **(804) 559-9900**	**Occupational Health Services @ Henrico Doctor's – Parham Rd** **Dr. D. Slagel** 7700 E. Parham Rd Henrico, VA 23294 **(804) 747-5627** **ONLY 8 AM to 4 PM** **Monday - Friday**	**Hanover Emergency Center** **Dr. D. Slagel** **Occupational Health** 9275 Chamberlayne Rd Mechanicsville, VA 23116 **(804) 417-0300 - ONLY** **Emergency/After Hours**

WORKERS' COMPENSATION ORTHOPEDIC SPECIALISTS:

YOU MUST VISIT A PANEL PHYSICIAN LISTED ABOVE BEFORE BEING TREATED BY ONE OF THESE SPECIALISTS.

You may ONLY choose from these approved Orthopedic Specialists for orthopedic treatment.
You MAY choose another location within these practices that is more convenient to you.

West End Orthopedics	**Tuckahoe Orthopedics**	**Ortho VA (was Advanced Ortho)**
Dr. Anthony Shaia 8266 Atlee Road Mechanicsville, VA 23116 (804) 730-2121	Dr. John Blank 1501 Maple Avenue, Suite 200 Richmond, VA 23226 (804) 285-2300	Dr. Anthony Shaia 7858 Shrader Road Richmond, Virginia 23294 (804) 270-1305

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION

EMPLOYEE'S ACKNOWLEDGEMENT OF PANEL OF PHYSICIANS

I understand that I must select a Panel Physician, if needed, from the list which has been given to me.

If I decline to select a Panel Physician from the list approved by Hanover County Public Schools, I understand that I will have to pay for any medical treatment or physician's bills. I also understand I may be denied Workers' Compensation benefits for any absence based on a disability not certified by an approved panel physician.

_____ _____

Employee's Signature Date

COMPLETE and FAX pages 5 – 10 to Michele Little, HCPS – HR @804-365-4583 as soon as possible to report a workplace accident or injury.

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION

EMPLOYEE ACCIDENT REPORT

(TO BE COMPLETED BY EMPLOYEE ON THE DAY OF INCIDENT/INJURY)

Employee Name_____ Date of Accident _____
Last Name, First, MI

Street Address _____ Time of Accident _____

City, State, ZIP _____ Primary Phone _____

Social Security Number _____ Date of Birth _____

Position/Location _____ Marital Status _____

Where did the accident occur? **(Exact facility and location at the facility)**
What were you doing prior to accident **(be specific)?**

Describe Accident **in Detail** (lack of detail may result in the claim being denied. Include photos, if possible**)**:

First Aid Given ❒ Yes ❒ No By Whom _____ Type of First Aid _____

Are you seeking medical attention by a Panel Physician? _____ Physician _____

List names of those who witnessed the accident:

Supervisor to whom the accident was reported and date reported:

Apparent injury: (**BE SPECIFIC!** Please check beside all which may apply)

_____ None Apparent	_____ Laceration-Small	_____ Scald-Burn
_____ Bruise	_____ Laceration-Large	_____ Bite
_____ Sprain	_____ Fracture	_____ Puncture
_____ Strain	_____ Scrape	_____ Dislocation

Other: _____

Location of Injury: (**Indicate Left or Right**)

_____ Hand (L / R)	_____ Shoulder (L / R)	_____ Knee (L / R)
_____ Eye (L / R)	_____ Foot (L / R)	_____ Elbow (L / R)
_____ Nose	_____ Chest	_____ Wrist (L / R)
_____ Teeth-Mouth	_____ Back	_____ Ankle (L / R)
_____ Arm (L / R)	_____ Abdomen	_____ Leg (L / R)

Other: _____

Probable Cause of Accident:

_____ Contact with fixed object	_____ Contact with Person	_____ Hit by Free Object
_____ Slip/Trip (Did not Fall)	_____ Slip/Trip/Fall	_____ Hit by Controlled Object
_____ Lifting Object	Other _____	

Any Contributing Factors: _____

The above statements are true, correct, and describe my accident to the best of my knowledge and belief.

_____ _____

Employee's Signature Date

COMPLETE and FAX pages 5 – 10 to Michele Little, HCPS – HR @804-365-4583.

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION
PHYSICAL CAPABILITIES FORM

(TO BE COMPLETED BY PHYSICIAN)
The HCPS Return to Work Medical Certification Form may be substituted for this form.

Patient's Name _____ Injury Date _____

Injury/Complaint(s) _____

Specific Diagnosis _____

Is the complaint(s)/diagnosis work-related? ❒ Yes ❒ No

Patient may return to work with ❒ Regular ❒ Restricted duties on _____
(Date)

- Work restrictions (include specifics and parts of body involved) _____

  _____

- Length of restrictions (number of days) _____
- Medications prescribed _____
- Does medication prevent patient from working on or around moving equipment, machinery, or driving?

  ❒ Yes ❒ No If "yes" please explain _____

  _____

Date of follow-up appointment _____

If referred, Physician's name _____

Other specific information to determine if this employee may resume their work duties _____

_____

Are light duty and work restrictions specific and medically necessary? _____

Physician's Name _____ Physician's Signature _____

Address _____ Date _____

_____

COMPLETE and FAX pages 5 – 10 to Michele Little, HCPS – HR @804-365-4583
as soon as possible to report a workplace accident or injury.

Invoices should be mailed to: Sedgwick/CMS, PO Box 14663, Lexington, KY 40512-4663. *Please include medical records with invoicing.* If desired, you may contact Michele Little at (804) 365-4688 to determine the claim number and insurance adjuster's name.

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION

SUPERVISOR'S INCIDENT ANALYSIS REPORT

(TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR)

Employee Name _____ Position: _____

Person Completing Report: _____ Contact Number: _____

Complete Description of Incident:

Date of Accident: _____ Time of Accident: _____ ❒ a.m. ❒ p.m.

Exact Location Where Accident Occurred: _____

What was employee doing prior to incident: _____

_____

Describe accident **in detail** (lack of detail may result in the claim being denied): _____

_____

_____

Persons Interviewed: (attach contact numbers and details if necessary)

_____

_____

Injury: ❒ Yes ❒ No Property/Vehicle Damage: ❒ Yes ❒ No

Was the employee performing his/her job? ❒ Yes ❒ No How long in this position: _____

What safety equipment/procedures apply? _____

Were they used? ❒ Yes ❒ No

Contributing Factors (How and Why did it happen?)

_____

_____

Action Plan (To prevent recurrence):

_____

_____

When will corrective action plan be completed? _____

Who is responsible for corrective action? _____

Do you question the validity of this claim? ❒ Yes ❒ No

Employee's Supervisor Signature _____ **Date** _____

Workplace Safety Officer's Signature _____ **(Required)** **Date** _____

COMPLETE and FAX pages 5 – 10 to Michele Little, HCPS – HR @804-365-4583
as soon as possible to report a workplace accident or injury.

HANOVER COUNTY PUBLIC SCHOOLS

WORKERS' COMPENSATION

STATEMENT OF EMPLOYEE'S WORK STATUS

(TO BE COMPLETED BY EMPLOYEE'S SUPERVISOR)

Employee's Name _____

Date and Time of Incident/Accident _____

Nature of Injury _____

☐ Employee did not seek professional medical attention.

☐ Employee did seek professional medical attention.

☐ Employee was taken via ambulance to emergency room.

Hospital _____

☐ Employee did not miss any work time beyond date of injury.

☐ Employee is currently out of work.

_____ _____

Supervisor's Signature Date

COMPLETE and FAX pages 5 – 10 to Michele Little, HCPS – HR @804-365-4583 as soon as possible to report a workplace accident or injury.

HANOVER COUNTY PUBLIC SCHOOLS

200 Berkley Street
Ashland, Virginia 23005-1399
Phone: (804) 365-4688
Fax: (804) 365-4583

TTY: (804) 798-7571

www.hcps.us
hanover@hcps.us

Return to Work Medical Certification

EMPLOYEE - This form must be submitted to the HCPS HR prior to your return to work or your return to work may be delayed.
Send completed form to HANOVER COUNTY PUBLIC SCHOOLS – Michele Little - HR Office – FAX: 804-365-4583.

EMPLOYEE Name (printed): _____ (signature):_____

By my signature above, I authorize my health care provider to provide the requested medical information in order for Hanover County Public Schools to make a determination of my eligibility to return to work. (date):

HEALTH CARE PROVIDER - Please complete the following information prior to the employee's return to work.

FULL DUTY Release Date - Employee is returned to FULL DUTY, NO RESTRICTIONS AS OF:_____(DATE).

MODIFIED DUTY Release Date - Employee is able to return WITH RESTRICTIONS AS OF:_____(DATE).

Please specify a transitioning schedule - if employee may return to part time hours: _____.

☐ The employee does not have any restrictions and will be able to perform all the essential functions of this job upon returning to work.

☐ The employee has the restrictions listed below and will not be able to perform the following essential job functions.

Work Duty Restrictions	Hours Per Work Day Able to Perform Activity									Restriction Release Date
	0	1	2	3	4	5	6	7	8	
Stand/Walk										
Sit										
Bend										
Squat										
Kneel										
Climb										
Reach										
Twist										
Push/Pull										
Grasp ☐ Right Hand ☐ Left Hand										
Lift _____ lbs.										
Carry _____ lbs.										
Operate Motor Vehicle										
Exposure Limitation (Specify)										

Additional restrictions:_____

Do you know of any health or medical reasons why this employee should not work with or supervise public school students? ☐ Yes ☐ No

If YES, please explain: _____

_____

Signature of Health Care Provider Date

_____ _____

Printed Name of Health Care Provider/Practice Phone Number Fax Number

_____ _____

_____

Mailing Address Street City State Zip