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 **Acknowledgment 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 **Return To Work Certification** 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 **First Report of Injury** form 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 **RTW Medical Certification Form** as soon as possible to the HCPS HR Office or ask the physician to fax this information directly to Michele Little, 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 Clinic **Dr. A. Thurman** 8200 Meadownbridge Rd. Suite 301 Mechanicsville, VA 23116 **(804) 442-3750**	**Hanover Family Physicians** **Dr. L. Blackburn, Jr.** **Dr. Micah Houghton** 9376 Atlee Station Rd Mechanicsville, VA 23116 **(804) 730-0990**	**Patient First – Short Pump** **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**	**Hanover Emergency Center** **Dr. D. Slagel** **Occupational Health** 9275 Chamberlayne Rd Mechanicsville, VA 23116 **Emergencies ONLY** **(804) 417-0300**

WORKERS' COMPENSATION ORTHOPEDIC SPECIALISTS:

YOU MUST HAVE A REFERRAL FROM 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.

Alliance Physical Therapy/Orthopaedic Dr. T. Camden 5211 West Broad St, #101 Richmond VA 23230 (804) 288-3025	**Tuckahoe Orthopedics** Dr. S. Wolfe 1501 Maple Avenue, Suite 200 Richmond, VA 23226 (804) 285-2300	**Ortho VA** Dr. D. Wills 8200 Meadowbridge Rd. Suite 200 Mechanicsville, VA 23116 (804) 730-2121

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 – 8 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

Action Plan to Prevent Recurrence: _____

_____

_____ _____
Employee's Supervisor Signature Date

_____ _____
Workplace Safety Officer's Signature Date

TO BE COMPLETED BY THE EMPLOYEE'S SUPERVISOR/SAFETY OFFICER

First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for filing: _____
VWC Jurisdiction Claim #: (If assigned) _____
Claim Administrator File#: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Hanover County Public Schools/Hanover Co., School Board	546001342

Employer's Mailing Address

200 Berkley Street
Ashland, VA 23005

Name/FEIN of Entity on Policy	Nature of Business
546001342	School System
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number
School Systems of Virginia, GSIA c/o Sedgwick CMS 1800 Bayberry Court, Suite 200 Richmond, VA 23226	School Systems of Virginia, GSIA 2475 00626019

Time and Place of Accident

Location where accident occurred	Date of injury	Hour of injury
		☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death	If fatal, give marital status
	If fatal, give number of dependent children	☐ Single ☐ Divorced ☐ Married ☐ Widowed

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number (SSN)
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness

Describe fully how injury or illness occurred

Describe nature of injury, occupational disease, or illness, including body parts affected (i.e. bruise R arm

Signatures

Submitter (name, signature, title)	Date	Phone number

Submitter's Address

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

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.