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 Judith Marston in Human Resources at 365-4688 or via email at jmarston@hcps.us .

Please return with claim packet to Judith Marston in Human Resources

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.** **If you are eligible for Family & Medical Leave (FML), your time out of work may be counted as part of your 12 weeks of job protected leave under the Family Medical Leave Act.** FML coverage begins after 10 days away from work and may be used for up to 12 weeks, or 480 hours, and may be used intermittently. FML is unpaid leave which provides employees with a level of job protection even when paid leave is exhausted. Contact Judy Marston

in Human Resources at 365-4688 to initiate your Family Medical Leave and to obtain the forms for job protected coverage if you are out of work for medical or family 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 Judith Marston 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 Judith Marston 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 Judith Marston 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	Judith Marston (804) 365-4688 (804) 365-4583 FAX jmarston@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:

Bon Secours Good Health Express/Clinic 8200 Meadowbridge Rd Suite 301 Mechanicsville, VA 23116 **(804) 442-3750** **&** 9851 Brook Road Glen Allen, VA 23059 **(804) 893-8702**	**Hanover Family Physicians** 9376 Atlee Station Rd **&** 8266 Atlee Road #226 Mechanicsville, VA 23116 **(804) 730-0990**	**Patient First – Short Pump** 370 Pump Road, Henrico-23233 **(804) 360-8061** **Patient First – Mechanicsville** 7238 Mechanicsville Tnpk Mechanicsville, VA 23111 **(804) 559-9900**	**Occupational Health Services @ Henrico Doctor's – Parham Rd** 7700 E. Parham Rd Henrico, VA 23294 **(804) 747-5627** **ONLY 8 AM to 4 PM Monday - Friday**	**Hanover Emergency Center** 9275 Chamberlayne Rd Mechanicsville, VA 23116 **(804) 417-0300** **ONLY After Hours Emergency**

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
8266 Atlee Road
Mechanicsville, VA 23116
(804) 730-2121

Tuckahoe Orthopedics
1501 Maple Avenue, Suite 200
Richmond, VA 23226
(804) 285-2300

Advanced Orthopedics
7858 Shrader Road
Richmond, VA 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

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?

Describe Accident in **Detail**:

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: (Please check beside all which may apply)

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

Other: ____

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

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

Other: ____

Probable Cause of Accident:

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

Other ____________________

Any Contributing Factors: ____

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

________________________________ ________________________________

Employee's Signature Date

Please return with claim packet to Judith Marston in Human Resources

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 _________________________________

____

Please return form to: Hanover County School Board, ATTN: Judith Marston, Human Resources Dept., 200 Berkley Street, Ashland, VA 23005. **Fax # 804-365-4583**.

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 Judith Marston 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** ______________

Please return with claim packet to Judith Marston in Human Resources

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

HANOVER COUNTY PUBLIC SCHOOLS

200 Berkley Street
Ashland, Virginia 23005-1399
Phone: (804) 365-4866
Fax: (804) 365-4583
TTY: (804) 798-7571
www.hcps.us
hanover@hcps.us
Michael Gill, Ed.D.
Superintendent of Schools

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.
Completed form can be faxed/hand delivered to HANOVER COUNTY PUBLIC SCHOOLS – J Marston - HR Office – 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.

Employee is returned to FULL DUTY, with NO RESTRICTIONS AS OF ______________________(Date).

Release - Employee is released to return to REGULAR DUTY

☐ As of ______________________________(date)

Release - Employee is released to return to MODIFIED DUTY

☐ As of ______________________________(date)

With transitioning schedule for this employee, if restricted to part time hours or modified duties:

____

ACTIVITY	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