Workers' Compensation Handbook
2022 - 2023

Department of Finance
Risk Management

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Policy Number 8442

Contents

HOW TO REPORT A WORKPLACE INJURY

Call 911 in the event of life-threatening injury or illness.

STEP 1

Injured Employee Notifies a Supervisor of Incident.
Employee or Supervisor calls the Workers' Compensation office at 772-564-3130 or 772-564-3129. After hours call 772-217-9466.

STEP 2

Complete the following forms as attached *before* obtaining treatment:

- First Notice of Injury or Illness
- Medical Care Acknowledgement Statement
- Occupational Safety Report

STEP 3

Email completed forms to the Workers' Compensation office at: Dist.CO.WorkersCompClaims@indianriverschools.org to receive treatment authorization.

Treatment must be authorized in advance by the Workers' Compensation (WC) office unless it is a life-threatening emergency. The WC office will provide the employee with an authorization form to take to the WC authorized physician.

What happens next?

The injured worker is required to report back to work following all WC treatment and provide documentation of their work status or call the WC office regarding their work status if they are unable to report back to work.

Additional medical services: The WC Office must authorize additional medical services (labs, x-rays, testing, specialist, follow-up) before appointments can be scheduled and or services provided. The WC specialist will coordinate with the employee, their supervisor, and the provider. Unauthorized treatment will not meet WC standards nor be reimbursed. Call the WC office to obtain the necessary authorization.

All authorized WC appointments will be excused absences. Every effort will be made to schedule appointments at the beginning or end of the workday to avoid disrupting the work schedule. The WC office will inform the supervisor of the employee's work status following the injury and coordinate work restrictions and or light duty if necessary.

Prescriptions: Workers' Compensation has its own prescription plan. Do not use a personal card. The WC office will provide a WC authorization letter for prescriptions. Call the WC office to obtain the form.

COMO REPORTAR UNA LESION EN EL LUGAR DE TRABAJO

EN CASO DE EMERGENCIA LLAME 911

Paso 1

El empleado lesionado notifica a un supervisor del incidente.
El empleado o supervisor llama a la oficina de compensación de trabajadores al 772-564-3130 o al 772-564-3129.

Después de las 5:00 p.m. llame a 772-217-9466.

Paso 2

Complete los siguientes formularios adjuntos antes de recibir tratamiento:

- First Notice of Injury or Illness (aviso de lesión o enfermedad)
- Medical Care Acknowledgement Statement
  (Declaración de reconocimiento de atención medica)
- Occupational Safety Report (Informe de Seguridad Laboral)

Paso 3

Envie por correo electronico los formularios completados a la oficina de compensacion para trabajadores a: Dist.CO.WorkersCompClaims@indianriverschools.org para recibir autorizacion de tratamiento.

El tratamiento debe ser autorizado por adelantado por la oficina de compensación para trabajadores a menos que sea una emergencia que ponga en peligro la vida. La oficina de compensación para trabajadores proporcionara al empleado un formulario de autorización para llevar al médico autorizado.

¿Qué pasa después?

Se requiere que el trabajador lesionado se presente a trabajar después de todo el tratamiento y proporcione documentación de su estado laboral o que llame a la oficina de compensación para trabajadores con respecto a su estado laboral si no puede regresar a trabajar.

Servicios médicos adicionales: La oficina de compensación para trabajadores debe autorizar servicios médicos adicionales (análisis, radiografías, pruebas, especialistas, seguimiento) antes de que se puedan programar las citas y/o brindar los servicios. El especialista en compensación para trabajadores coordinará con el empleado, su supervisor y el proveedor. El tratamiento no autorizado no cumplirá con los estándares de compensación para trabajadores ni será reembolsado. Llame a la oficina de compensación para trabajadores para obtener la autorización necesaria.

Todas las citas autorizadas serán ausencias justificadas. Se hará todo lo posible para programar citas al principio o al final de la jornada laboral para evitar interrumpir el horario de trabajo. La oficina de compensación para trabajadores informará al supervisor sobre el estado laboral del empleado después de la lesión y coordinará las restricciones laborales y/o el trabajo ligero si es necesario.

Recetas: La Compensación para Trabajadores tiene su propio plan de recetas. No utilice una tarjeta personal. La oficina de compensación para trabajadores proporcionará una carta de autorización de para recetas. Llame a la oficina de compensación para trabajadores para obtener el formulario.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours
1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIM-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

Name (First, Middle, Last)	Social Security Number	Date of Accident	Time of Accident ☐ AM ☐ PM
Home Address Street/Apt. #: City: State: FL Zip:	Employee's Description of Accident (Include Cause of Injury)		
Telephone: Area Code Number			
Occupation: Date of Birth: Sex ☐ M ☐ F	Injury/Illness That Occurred	Part of Body Affected	

EMPLOYER INFORMATION

Co. Name: School District of Indian River Co. D.B.A.: Street: 6500 57th Street City/State Zip: Vero Beach FL 32967	Federal ID Number (FEIN) 59-6000673	Date First Reported (Month/Day/Year)
Telephone: (Area Code) Number	Nature of Business Education	Policy/Member Number
Employer's Location Address (if different) Street: City/State/Zip: FL Location #	Date Employed	Paid for Date of Injury ☐ Yes ☐ No
	Last Date Employee Worked	Will you continue to pay wages instead of Workers' Comp? ☐ Yes Last day wages will be paid instead of Worker's Comp.
	Returned to Work ☐ No If Yes, Give Date ☐ Yes	Rate of Pay $_____ Per ☐ HR ☐ WK ☐ DAY ☐ MO
Place of Accident (street, city, state, zip) School/Department: Street: City/State/Zip: County of Accident:	Date of Death (If applicable)	Number of hours per day Number of hours per week Number of days per week
	Agree with description of accident? ☐ Yes ☐ No	

Any person, who knowingly and with intent to injure, defraud, or deceive any employer or employee, Insurance Company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234. Section 440.105(7), F.S.

Name, Address Telephone and Fax of Physician or Hospital

CareHere
5525 41st Street
Vero Beach, Florida 32967
Phone: (772) 617-2300

Call 911 or go to the nearest Emergency Room for life threatening injuries or illnesses.

Employee Signature (if available) Date

Employer Signature (if available) Date

Authorized by Employer ☐ Yes ☐ No

CLAIMS-HANDLING ENTITY INFORMATION

1a. ☐ Case Denied - DWC-12, Notice of Denial Attached
1b. ☐ Indemnity Only Denied Case - DWC-12, Notice of Denial Attached
2. ☐ Medical Only which became Lost Time Case (Complete all info in #3)
Employee's 8th Day of Disability _____/_____/_____
Entity's Knowledge of 8th Day of Disability _____/_____/_____
3. ☐ Lost Time Case -- 1st day of disability __/__/__ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____

Date First Payment Mailed _____/_____/____ AWW _____ Comp Rate_____

☐ T.T. ☐ T.T.-80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ Death ☐ Settlement Only

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

Remarks:		Insurer Name: **School District of Indian River County** Claims-Handling Entity Name, Address & Telephone
INSURER CODE # 9288	Employee's Class Code (Select Class Code)	Employer's NAICS Code 611110
Service Co/TPA Code # 6060	Claims-Handling Entity File #	**Relation Insurance & Benefits Solutions, Inc** **700 Central Parkway** **Stuart, FL 34994** **1-800-431-2221**

2022-2023 Risk Management Medical Care Acknowledgement Statement

DWC-1 Purpose and Use Statement: The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier by the Division of Workers' Compensation database for individuals who have claimed benefits under Chapter 440, FS. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits for internal agency tracking purposes and for purposes of responding to both public records request and subpoenas that require production of specified documents under the law. Your social security number may also be used for any other purpose specifically required as authorized by state or federal law. **Authorization to Furnish Medical/Employment Information:** In order to assist with the handling of my claim with Relation Insurance Services, I authorize my employers and all persons with knowledge of my injuries to furnish employment and medical information to Relation. My understanding of this authorization is as follows: **Information to Be Released**: Relation may request all information related to my claim, including information related to diagnosis, treatment records and bills, medical histories, assessments of past, current, and expected physical condition as well as current and historical employment, wage, and benefit information. Relation may either review or photocopy this information. **Sources of Information**: Relation may contact the appropriate medical providers, insurance companies, and employers and provide them with a copy of this authorization to obtain the necessary information. **Use of Provided Information**: Relation and its representatives (such as medical providers or lawyers) retained by Relation will use this information to verify and evaluate my claim to determine any appropriate resolution. Relation may also release the information to professional organizations whose purpose is to detect insurance fraud and may release it to other insurance companies to whom a claim has been or may be submitted. **Time Period of this Authorization:** I understand that this authorization will remain valid until my claim with Relation is legally concluded. I also understand that I can revoke this authorization at any time by notifying Relation in writing. **Copies of this Authorization:** I can request a copy of this signed authorization at any time from Relation.

Medical Care Acknowledgement Statement: (Please circle one) **I DO or DO NOT wish to seek medical attention at this time**. Medical care is available at the preauthorized provider as identified on the front of the First Notice of Injury form (DWC-1). Should I need medical attention at a later date, concerning this incident, I understand that it is available up to two years from the date of the injury and that I will notify my immediate supervisor and the Risk Management Department. All treatment must be preauthorized.
THIS IS NOT A RELEASE OF MY CLAIM. I UNDERSTAND THAT SIGNING THIS FORM DOES NOT MEAN I HAVE SETTLED MY CLAIM. ALL RIGHTS AND RESPONSIBLTIES REMAIN IN EFFECT. Please call the Risk Management Department at 772-564-3129 if you should need additional information.

_____	_____	_____
Print Name	Date	Signature
_____	_____	_____
Witness Name	Date	Signature

2022-2023 Risk Management Occupational Safety Report

Purpose: To ensure that occupational safety and hazard policies and procedures are properly in place and to correct those that are not.

Objective: All accidents are investigated, recorded and promptly reported. Each workplace injury or illness shall be documented on this form.

Instructions: Please write legibly. The injured worker shall complete section A and section E of this report and attach it to the First Notice of Injury Report. Both forms shall be submitted to the supervisor *before obtaining treatment.* *TREATMENT must be preauthorized by Risk Management except for life-threatening emergencies.* The injured worker's supervisor shall complete section B and submit both forms to the School Principal or Department Administrator who in turn shall complete Section C and submit both forms to Risk Management for treatment authorization. Risk Management will forward the forms to the Assistant Superintendent or Superintendent for completion of section D and compile the data to report back to all parties.

SECTION A. INJURED WORKER

1.Name	2.School/Dept:	
3.Date of accident:	4.Job Title	
MM/DD/YYYY Time: AM PM	5.Address of Accident	
6.Specific location of accident:	City	State
7.What were you doing at the time of the accident?		
8.What were you doing just before the accident?		
9.**Describe the accident**. On the lines below carefully tell what happened in your own words. Please make sure to write a statement to answer the questions: Who? What? When? Where? How and or Why did it happen. Use the back of this report if you need more room.		
10. Did the accident/incident involve a traffic report or a police report? If so, please provide a copy of the report or report number. If SDIRC Vehicle provide Unit ID# and accident report.		
11.Were there witnesses? Name:	Title:	Phone Number:
12. More than one witness? Name:	Title:	Phone Number:
13.What do you recommend could have been done to prevent this accident from occurring?		
14.Employee Signature:	Date:	Phone Number:

SECTION B. INJURED WORKER SUPERVISOR

15. Supervisor's Name	Title:	Phone Number:
16.Was the area secured? Yes No Not Necessary	17. Specify location:	
18.Pictures/Video documented sent to Maintenance/Facilities/Risk?	19. Sketch Accident Scene below	
20. What was the root cause of the accident?	Develop a Corrective Action Plan below and be specific to root cause of accident.	

21. What will be done to prevent reoccurrence?	22. When will the corrective action be completed? (date)	23.Who is responsible for getting it done?

Supervisor Signature:	Supervisor Print Name:	Date:

SECTION C. SCHOOL PRINCIPAL/DEPARTMENT DIRECTOR

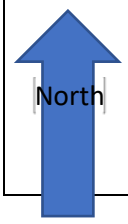
24. Principal/Department Director Name:		Phone Number:
25. Do you agree with the above findings? Why or Why not?		
26. When will you follow-up to ensure compliance with the corrective action plan? What date?		
School Principal/Department Director Signature:		Date:

SECTION D. ASSISTANT SUPERINTENDENT/SUPERINTENDENT

27. Assistant Superintendent/Superintendent		Phone Number:
28. Do you agree with the above findings? Why or Why not?		
29. Were all the Correction Action Plans completed?	Additional recommendations?	
30.Assistant Superintendent/Superintendent Signature:		Date:

SECTION E. ACCIDENT ILLUSTRATION

Sketch accident scene here. Draw a diagram to illustrate the scene of the accident, note the location of equipment, fixed objects, desks, chairs windows, doors, walkways, gates, personnel, vehicles, and landmarks. Note anything you think may be significant. Use the back of this report if you need more room.



Email your completed section of this report to: RiskManagementincidents@indianriverschools.org.

Thank you - Safety matters.