NOTICE TO EMPLOYEES INJURED ON THE JOB

In compliance with Board policy **GBRIG**, procedures related to employees injured on the job must be strictly followed in recouping medical expenses or reinstatement of sick days if absences are incurred due to the injury. Failure to follow the guidelines established could result in a denial of your request.

EMPLOYEE INSTRUCTIONS:

1. Notify your immediate supervisor within 24 hours after the injury occurred. Complete and sign the ***Incident or On-The-Job Injury Report*** (page 2 of 4) and submit it to your supervisor, who will sign and return the form to Dr. Maddox at Central Office.

2. If medical attention is required due to an injury, Board policy states that the employee has 48 hours to see a physician (not at Board expense). The attending physician should complete the ***Physician Certification Form*** (page 3 of 4) to validate that the employee's injury would not allow him/her to return to work, and also assist in authenticating their request for pay without loss of sick leave days. This form must be submitted to your supervisor when completed unless hospitalization would delay this process.

   Dr. Maddox will present the ***Incident or On-The-Job Injury Report,*** along with the ***Physician Certification*** to the Superintendent for Board approval to provide salary continuation without loss of sick leave days. (Payment for time lost from work due to an on-the-job injury may not exceed 100% of the employee's regular salary rate. Such salary continuation may be made only for temporary disabilities if there is a reasonable expectation that the employee WILL return to work within a reasonable period of time. In no case shall any employee's salary continuation, without loss of sick leave days, exceed 90 working days for any one (1) on-the-job accident. Board policy states that there is nothing precluding an employee who is absent due to a job-related injury, from using accumulated sick leave or the sick leave bank, if eligible. (Completion of the ***FMLA and Catastrophic Sick Leave Request*** form would be required).

3. If out-of-pocket medical expenses are incurred due to an injury, employees of the Homewood Board of Education have the right to file a claim with the State Board of Adjustments, requesting reimbursement. This claim must be submitted no later than one year from the date of the injury due to the statute of limitations. If ongoing treatments are necessary beyond the first year, you must file a claim each year seeking reimbursement. The Homewood Board of Education is not affiliated with the state Board of Adjustments, therefore, **IT IS THE EMPLOYEE'S RESPONSIBILITY TO FILE A CLAIM.** To review the Rules of the Alabama Board of Adjustment and obtain claim forms, go to: www.bdadj.alabama.gov

4. Using the ***Return to Work Medical Evaluation Form***, obtain clearance and/or directives from your physician and submit this form to your supervision upon your return to work. Should you fail to get unrestricted clearance from your physician please share that information and restrictions with your supervisor so it can be determined if restrictions will inhibit your ability to perform your duties (as defined in your current job description) safely and effectively. Communication is key.

INCIDENT or
ON-THE-JOB ACCIDENT REPORT

1. NAME OF INJURED (Please Print/Type)

_____ _____ _____ M / F

Last First Middle Initial Social Security Number Date of Birth Gender (pls. circle)

2. HOME ADDRESS

_____ _____ _____ _____

Number & Street City State Zip Home Phone Work Phone Cell Phone

3. STATUS

___ Employee _____ _____ _____

___ Student Job Title/Position School/Location Address

___ Visitor

4. DATE of INJURY: _____ Time: _____AM/PM Date Reported to Supervisor: _____

Was Medical Treatment Received? ____ Yes ____ No Treatment Date: _____

Is injured covered by medical insurance? ____Yes ____ No

If yes ____Blue Cross/Blue Shield ____Other: _____

Name/Address of Attending Physician _____

Name Address

5. Type of Injury **Type of Treatment**

safely and effectively__ Emergency Treatment

_____

__ ____ Outpatient Name of medical facility where treated

cut/fall/burn, etc ____ Hospitalized

Please use back for add'l space & attach documentation if needed

6. Describe fully what happened to cause the injury or illness (include the exact location of occurrence)

7. Describe the injury or illness in detail and indicate the body part(s) affected (right or left).

8. Were there any witnesses to the injury? ___Yes ___ No (If "Yes" give name, address, and phone number)

9. Was the employee able to return to work? ____ Yes ___ No

I am aware that I must talk with my principal/supervisor if I miss work due to this injury and submit this report within 24 hours of the injury. I am aware that the statute of limitations for filing an injury claim with the Alabama State Board of Adjustment is one year from the date of the injury. I understand filing a false injury claim may disqualify me from receiving benefits/compensation and all injury reports are subject to an investigation.

_____

Signature of injured person or person reporting PRINT Name Daytime Phone Number Today's Date

_____

Signature of Supervisor (or designated authority) PRINT Name Daytime Phone Number Today's Date

PHYSICIAN CERTIFICATION FORM

*ATTENTION: THE ATTENDING PHYSICIAN **MUST** COMPLETE THIS FORM IN FULL*

Alabama Public Schools are not eligible for Workmen's Compensation and require this form to be completed for Employee Reimbursement with the Alabama Board of Adjustment

1. NAME OF INJURED (Please Print/Type)

_____	_____	_____	M / F
Last First Middle Initial	Social Security Number	Date of Birth	Gender (pls. circle)

2. HOME ADDRESS

_____	_____	_____	_____
Number & Street City State Zip	Home Phone	Work Phone	Cell Phone

3. Employing Agency – Homewood City Schools, 450 Dale Avenue, Homewood, AL 35209

4. DATE of INJURY: _____

5. Is there a reasonable expectation that the employee will be able to return to work? ____ Yes ____ No

If **YES**, please give date or approximate date of return _____

If the employee can return to work, are there any restrictions on the employee's duties and length of time the restrictions apply? _____

If **NO**, give details for employee not being able to return to work. _____
_____

Is the attending physician referring this employee to another physician or medical agency? ____ Yes ____ No

If **YES**, name the physician or medical agency of the referral.

_____

Signature of Attending Physician Print Name Telephone Number Date

Name of Medical Facility and Address_____

Attention Employee: This form **MUST** be returned to the principal/supervisor if medical attention was required due to injury.

RETURN TO WORK
MEDICAL EVALUATION FORM

NOTE TO PHYSICIAN: We need your assistance in protecting the health and wellbeing of the patient listed below. Your answers will help determine whether the employee needs to **1)** be away from work for further rehab and/or recovery, or **2)** if they could return – upon supervisor's agreement, on a restricted basis, or **3)** if they have been fully cleared by you and it has been determined they can resume their responsibilities with no restrictions or alterations to their work day and workplace, based on the job description provided. Please answer the following questions to the best of your knowledge.

Name of Patient _____

Date of injury/surgery/onset of illness_____ **Date of Exam** _____

Diagnosis/description of injury/surgery/illness_____

The patient's return to work status is:

___ Return to regular work. Effective _____

___ Able to return to work with noted restrictions. Effective _____

___ Unable to return to work until next evaluation, scheduled for _____

___ Referred to another health care provide for additional evaluations – please provide name of health care provider _____

Lifting Restrictions:

___ NONE ___ 10 –19 lbs ___ 20 – 29 lbs

___ 30 – 39 lbs ___ 40 – 50 lbs

Follow-up Plan of Treatment:

___ NONE
___ Return visit on _____ at _____ am/pm

Additional comments:

_____

_____

_____

Signature of physician Printed Name Date

_____

Office Address Office Phone Number