WORKERS’ COMPENSATION PACKET

DUPLICATE AS NEEDED

PLEASE POST COPY OF PACKET ON BULLETIN BOARD IN MAIN OFFICE FOR EASY ACCESS WHEN EMPLOYEE INJURIES OCCUR.

USE FOR EMPLOYEE INJURIES ONLY!

FROM THE OFFICE OF RISK MANAGEMENT

ANDREW DAVIS,
DIRECTOR OF RISK MANAGEMENT
6550 SEVEN OAKS, RM. #10
BATON ROUGE, LA 70806
PHONE: 225-929-8683
FACSIMILE: 225-929-8707

Updated (01/6/14)
NOTE: IT IS THE RESPONSIBILITY OF THE PRINCIPAL/SUPERVISOR AND/OR THE
PRINCIPAL’S/SUPERVISOR’S DESIGNEE TO PROCESS AND MAIL THE APPROPRIATE
DOCUMENTS TO THE OFFICE OF RISK MANAGEMENT WITH-IN 48 HOURS.

Forms:

6-11 AUTHORIZED MEDICAL FACILITY
Is Employee going to an authorized clinic? Do Not Allow Employee to Drive!
Clinics are preferred over emergency rooms.
Please utilize Occupational Medicine Clinic’s 24 hour Emergency # 378-7884.
Remind the Employee: Job related injuries are not covered by health insurance.

6-12 AUTHORIZATION FOR EMPLOYEE MEDICAL TREATMENT
Requires Principal/Supervisor/Designee’s signature, and that they accompany the Employee to the Clinic.
Employee returns a copy to you with their work status.
  Can the employee return to work?
  If the employee has restrictions, please call and let’s discuss.
Return a copy to the Office of Risk Management

6-12A “HIPPA COMPLIANT” – Authorization for Release of Information
Employee is to sign and return to the Office of Risk Management

6-13 RESTRICTED DUTY POSITIONS
Goes with the Employee to the Clinic to be given to the doctor.

6-14 ACKNOWLEDGEMENT OF UNDERSTANDING (Information about payments, ins., etc.)
Give to employee to read and sign.
Return original to the EBRPSS’s Office of Risk Management.

6-15 SUPPLEMENTAL SICK LEAVE
Give to employee to read and sign.
Return original to the EBPRESS’s Office of Risk Management.

6-16 WORKER’S COMPENSATION – EMPLOYER REPORT OF INJURY/ILLNESS
Complete as much information as possible.
Requires Principal/Supervisor/Designee’s signature.
***Return original to the EBRPSS’s Office of Risk Management.***

6-17 PRINCIPAL/SUPERVISOR’S INVESTIGATION REPORT – WORKER’S COMPENSATION
Requires an investigation of the accident.
Requires Principal/Supervisor/Designee’s signature.

6-18 FIRST AID LOG
Record all employee injuries that did NOT require a doctor visit.
Submit monthly to the EBRPSS’s Office of Risk Management (W/C).

From the Office of Risk Management
Andrew Davis, MPA, BS
Goodwood Center
6550 Seven Oaks, Rm. #10
Baton Rouge, LA 70806
Phone: 225-929-8683 Facsimile: 225-929-8707

Revised 01/14

Form 6-10
Thank you for your compliance with our workers compensation procedures:

1. Call EBRPSS's Office of Risk Management (225) 929-8683 or 929-8686 immediately after a decision has been made that an injured employee needs to go to the doctor.
2. Make sure the Workers Compensation Packet is completed and faxed to (225) 929-8707 before employee leaves site.
3. It is at the administrator's discretion on how the employee should be transported.
4. Injured employees should take form 6-12 of the Workers Compensation Packet (Authorization for Employee Medical Treatment) along with them to the doctor.
5. Remind the employee and the doctor's office that the injury is to be handled through Workers Compensation, NOT employee health plan.

Please direct all job related injuries to one of the following locations for initial treatment:

<table>
<thead>
<tr>
<th>CLINIC</th>
<th>LOCATION</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Remede Clinic***</td>
<td>3235 Perkins Road</td>
<td>225.387.3030</td>
</tr>
<tr>
<td>Total Occ. Medicine Clinic***</td>
<td>3333 Drusilla Lane</td>
<td>225.924.4460</td>
</tr>
<tr>
<td>Lake After Hours Clinic***</td>
<td>3333 Drusilla Lane</td>
<td>225.924.3906</td>
</tr>
<tr>
<td>After Hours Emergencies &amp; Drug Screening</td>
<td>3333 Drusilla Lane</td>
<td>225.378.7884 (pager)</td>
</tr>
<tr>
<td>Ochsner Clinic Baton Rouge</td>
<td>2345 O'neal Lane</td>
<td>225.761.5492</td>
</tr>
<tr>
<td></td>
<td>9001 Summa Avenue</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Rooms- IF NOT MEDICAL EMERGENCY USE CLINICS ABOVE***

<table>
<thead>
<tr>
<th>CLINIC</th>
<th>LOCATION</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baton Rouge General</td>
<td>8585 Picardy Avenue</td>
<td>225.763.4000</td>
</tr>
<tr>
<td>Our Lady of the Lake</td>
<td>Entrance on Essen Lane</td>
<td>225.765.8826</td>
</tr>
<tr>
<td>Lane Memorial</td>
<td>6300 Main Street, Zachary</td>
<td>225.658.4335</td>
</tr>
</tbody>
</table>
WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

<table>
<thead>
<tr>
<th>Employer (Name &amp; Address incl. zip):</th>
<th>Carrier/Administrator Claim Number</th>
<th>OSHA Log Number</th>
<th>Report Purpose Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction</td>
<td>Jurisdiction Claim Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured Report Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer's Location Address (If Different):</td>
<td>Location #:</td>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>Industry Code</td>
<td>Employer FEIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrier/Claims Administrator</td>
<td>Policy Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrier (Name, Address &amp; Phone #:)</td>
<td>To</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check if Appropriate</td>
<td>Self Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrier FEIN</td>
<td>Policy/Self-Insured Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agent Name &amp; Code Number</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EMPLOYEE/AGE

<table>
<thead>
<tr>
<th>Name (Last, First, Middle):</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Date Hired</th>
<th>State of Hire</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Incl. Zip):</td>
<td>Sex</td>
<td>Marital Status</td>
<td>Occupation/Job Title</td>
<td>Employment Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>Unmarried</td>
<td>F</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OCCURRENCE/TREATMENT

<table>
<thead>
<tr>
<th>The Employee Began Work</th>
<th>Date of Injury/Injury</th>
<th>Time of Occurrence</th>
<th>AM</th>
<th>PM</th>
<th>Last Work Date</th>
<th>Date Employer Notified</th>
<th>Date Disability Began</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name/Phone Number</td>
<td>Type of Injury/Injury</td>
<td>Part of Body Affected</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did Injury/illness/exposure occur on employer's premises?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department or Location where accident or illness exposure occurred</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Activity the Employee Was Engaged in When the Accident or Illness Exposure Occurred</th>
<th>Work Process the Employee Was Engaged in When Accident or Illness Exposure Occurred</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How Injury or Illness (Abnormal Health Condition) Occurred</th>
<th>Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Returned to Work</th>
<th>If Fatal, Give Date of Death</th>
<th>Were Safeguards or Safety Equipment Provided?</th>
<th>Were They Used?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital or Off Site Treatment (Name &amp; Address):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician/Health Care Provider (Name &amp; Address):</th>
<th>Initial Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital or Off Site Treatment (Name &amp; Address):</td>
<td>No Medical Treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witnesses (Name &amp; Phone #:)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Administrator Notified</td>
<td>Date Prepared</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------</td>
</tr>
</tbody>
</table>

LWC-WC IA-1

Form 6-14

IAIABC 2002
Facility Name

NAME OF EMPLOYEE: ___________________________ OCCUPATION: ___________________________

DATE OF HIRE: ___________________________ HOW LONG IN OCCUPATION: ___________________________

DATE OF INCIDENT: ___________________________ TIME OF INCIDENT: ___________________________ DATE REPORTED: ___________________________

EXACT PLACE OF INCIDENT: ___________________________

NAME OF EMPLOYEE'S IMMEDIATE SUPERVISOR: ___________________________

WHERE WAS THIS SUPERVISOR AT THE TIME OF THE INCIDENT: ___________________________

DESCRIBE THE INCIDENT: include a diagram on the back of this form if needed. Photographs [ ] Yes, [ ] No

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

DESCRIBE THE INJURY/DAMAGE: ___________________________

TREATMENT PROVIDED: [ ] None [ ] Onsite First Aid [ ] Hospital Date Admitted: ___________________________

[ ] Doctor

WHAT CAUSED THE INCIDENT TO HAPPEN? (Do Not Say "Carelessness"): ___________________________

_______________________________________________________________

CORRECTIVE ACTION YOU HAVE TAKEN TO PREVENT THIS FROM HAPPENING AGAIN: ___________________________

_______________________________________________________________

RECOMMENDATIONS TO OTHER FACILITIES TO AVOID SIMILAR ACCIDENTS: ___________________________

_______________________________________________________________

WHAT SAFETY EQUIPMENT WAS IN USE?: ___________________________

INVESTIGATED BY: ___________________________ DATE: ___________________________

PRINCIPAL/SUPERVISOR: ___________________________ Signature: ___________________________ DATE: ___________________________

This investigation must be completed within 24 hours of your first notification of the incident. Use the back of this form or additional sheets for supplementary information or witness statements. Notify the Office of Risk Management 225-929-8683 or 225-921-3103 immediately by telephone if medical treatment is required or if property damage is expected to exceed $500.00.

Revised 10/69

Form 8-17
EAST BATON ROUGE PARISH SCHOOL SYSTEM
***AUTHORIZATION FOR EMPLOYEE MEDICAL TREATMENT***

The undersigned is an employee of the East Baton Rouge Parish School System. Please DO NOT administer drug screens unless authorized. Please send the completed original form with the employees so that he or she may return it to their supervisor. Send billings and authorization requests to FARA Insurance Services at 800.215.3272.

**RELEASE OF MEDICAL RECORDS AND REPORTS AND STATEMENT OF UNDERSTANDING OF RETURN TO WORK PROCEDURES**
(This release includes verbal and written communications)

You or any physician, hospital, clinic or medical care provider presently known or unknown to me, who may have or subsequently acquire such information are authorized to furnish to my employer, the East Baton Rouge Parish School System, its agents and or representatives, all information, facts and particulars including records, reports, medical history, physical condition, treatment rendered, X-rays, CT/MRI scans, or results of other diagnostic tests, diagnosis, prognosis, estimates of disability or recommendations for further treatment and statements of changes which may be requested and to furnish them copies of such.

This information is to be used for the purposes of evaluating and handling my claim for injury as a result of the accident on the date indicated below and for no other purpose, now or in the future. A photocopy of this form may be accepted with the same authority as the original.

I understand that I must report to my supervisor immediately upon being released by a physician to return to work with or without restrictions. I also understand that I must return to work for the next regularly scheduled work shift after my release date. If I choose not to return, I will be docked up to six days leave after which I will be placed on leave without pay.

<table>
<thead>
<tr>
<th>Employee Name (Please Print)</th>
<th>Social Security Number</th>
<th>Employee Signature &amp; Date</th>
</tr>
</thead>
</table>

**TO BE COMPLETED BY SUPERVISOR OR PRINCIPAL (Please Print)**

<table>
<thead>
<tr>
<th>Nature of Job Related Injury (Body Part)</th>
<th>Date of Accident/Injury/Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of School or Facility</th>
<th>Signature of Principal or Designee</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TO BE COMPLETED BY PHYSICIAN**

**[This is a Legal Document Please Type or Print Neatly]**

Initial Diagnosis:
Disposition (check one)
[ ] Patient is able to return to work with no limitation.
[ ] Patient is able to return to work with the following restrictions: __________________________
[ ] Patient is NOT able to return to work: __________________________ Date of return visit: __________________________
[ ] Patient is to be hospitalized. If checked, call Risk Management at 929.8686 or 929.8683.

__________________________________________
Signature of Physician or Authorized Representative Date

Physicians' Name and Address and Phone Number of Medical Facility ** Type or Print Neatly**

Revised 04/16 Copies: 1 (Original) Supervisor 2. Office of Risk Management (W/C) 3. Physician Form 6-12
RESTRICTED DUTY POSITIONS

ATTENTION: TREATING PHYSICIAN

The East Baton Rouge Parish School System has numerous Restricted Duty Positions for its employees who are disabled due to a job-related injury. The jobs

1. Require no lifting, bending, twisting or stooping and/or
2. Allow employees to sit, stand or walk as needed and/or
3. Require no overhead reaching and/or
4. Allow other reasonable accommodations.

Please contact the Office of Risk Management at 225.929.8686 prior to removing any employee from the job. This will allow us to consult as to whether or not accommodations can be made of which you would approve.

OFFICE OF RISK MANAGEMENT
Jocelyn Stewart, Risk Management Specialist
Phone: 225.929.8686
Fax: 225.929.8707

Revised 03/16
Authorization for Disclosure of Protected Health Information

I, ___________________________ authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below): all healthcare providers who have provided healthcare services to me.

2. I authorize the following person(s) and/or organization(s) to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

Name: ___________________________
Address: ___________________________

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):
   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments. I further specifically authorize the disclosure of psychotherapy notes, if any.

4. This information may be used by the carrier or representative to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) names above have taken action in reliance on this information.

6. This authorization expires 1 year from the date signed, or with the conclusion of my Workers’ Compensation claim, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction.

Signed: ___________________________ Date: ________________

Name: ___________________________
Address: ___________________________

Phone: ___________________________ SSN: ___________________________

Relationship or Authority of Personal Representative (if applicable)

---

1 Protected health information (PHI) is health information that is created by a health care provider, health plan or health care clearinghouse which relates to 1) the past, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 48 C.F.R. 164.508.

2 These laws apply to health plans, health care providers, and health care clearinghouses.
EAST BATON ROUGE PARISH SCHOOL SYSTEM

***Acknowledgment of Understanding***

Workers' Compensation
Wage Payments and Medical Benefits

1. It is the responsibility of the injured employee to return the completed Authorization for Employee Medical Treatment form to their supervisor within 24 hours.

2. Worker's compensation indemnity benefits are paid based on a percentage (66 2/3) of the employees' average weekly wage up to a maximum amount set by the State of Louisiana. Indemnity checks will be issued directly from FARA Insurance Services, our Third Party Administrators (800-215-3272), after the first week waiting period. The first 5 working days (waiting period) will be taken from the employees' sick leave balance unless the employee notifies their payroll clerk otherwise. Prescriptions and mileage related to the job injury are reimbursable.

3. The use of Sick Leave to supplement by-weekly indemnity benefits is optional. A Worker's Compensation Supplemental Sick Leave form must be completed and returned to the Office of Risk Management prior to the next scheduled payroll.

4. The use of health insurance in place of workers' compensation medical benefits is not permitted.

5. Deductions - Retirement Contributions and Health Insurance Premiums will not be deducted from the indemnity checks issued by FARA Insurance Services. Employees must bring cash, personal check or money order made payable to the East Baton Rouge Parish School System each payroll period if,

   a) the employee elects to make retirement contributions on workers' compensation earnings, or regular full time earnings,

   b) the employee wishes to maintain health insurance. If premiums are not paid the employees' and dependents' health coverage will be terminated.

   c) All Other Deductions are the responsibility of the employee with the individual companies.

6. The employee must report to their supervisor two days before every payroll period. Notify the supervisor immediately upon being released by a physician to return to work for the next regularly scheduled work shift. If an employee chooses not to return, they will be docked up to six days of sick leave after which they will be placed on leave without pay.

7. Employees involved in an accident or the near miss of an accident on the job will be tested for illegal drugs and alcohol. Refusal to take this test is considered a positive test under state law and is a violation of Board Policy. Under the law, a positive drug or alcohol test voids all workers' compensation benefits.

I understand these procedures as they have been explained to me and have received a copy.

Employee Name (Please type or print) ___________________________ Social Security Number ___________________________

Employee Signature ___________________________ Date ___________________________

Please return this form to the Office of Risk Management

Revised 10/09 Original – Risk Management Copy - Employee Copy - School/Job Site Form 6-14
Please check the appropriate box and return this form to the Office of Risk Management (W/C).

While I am not working as a result of my job related injury, I request that the school system issue me a check for the difference in my normal pay minus Worker’s Compensation Indemnity Benefits, and reduce my sick leave balance accordingly until such balance is exhausted.

[   ] YES  [   ] NO

_____________________________  ______________________________
Employee Name (Please Print)  Social Security Number

_____________________________  _________________
Employee Signature  Date

_____________________________  _________________
Supervisor/ Principal Signature or Designee  Date

ANY QUESTIONS, CONTACT JOCELYN STEWART AT 225.929.8686.

Please do not write below this line

Revised 03/16  Form 6-15