Workers' Compensation Injury Packet

This Workers' Compensation Injury Packet is designed to simplify and streamline the information Managers and Employees must provide after an on-the-job injury. (This packet is also available on our website at www.barrowga.org)

If you are injured on the job please notify your supervisor immediately, complete the Workers' Compensation Injury Packet and report for a drug test at Project Adam within 8 hours of the injury.

This packet contains the following documents.

First Report of Injury

The employee will normally complete this document if physically able to do so. Please compete Section A of this form. This **must** be turned in to Human Resources in order to coordinate care.

Panel of Physicians

If non-emergency medical attention is needed the employee will need to circle the doctor/practice they wish to see and return this with the First Report of Injury to Human Resources in order to coordinate care. Human Resources employees are the only individuals authorized to schedule appointments therefore all appointments must be scheduled through Human Resources.

Attention Injured Worker Form

This form will need to be provided to the Treating Physician or Facility. This will provide them with relevant billing information.

Temporary Medical Card

This is to be used by the employee if medication is needed.

Workers' Compensation Employee Responsibilities

This document provides the employee with responsibilities and expectations as it relates to their workers' compensation claim.

Accident Review and Recommendation Report

This document must be completed by the employee as well as by the supervisor. Please complete and return to Human Resources.

If you need emergency medical attention please go to the nearest hospital and notify your supervisor.

If you have questions or need assistance please contact Human Resources 770-307-3114.

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code

EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
Address		Phone Number	Employer FEIN
City	State / Zip Code	Employer E-mail	

INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
CLAIMS OFFICE	Name	Claims Office FEIN # / Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Address	City / State / Zip Code	

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑I – Insurer ❑S-Self-insurer ❑Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage per Week If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

❑ B. INCOME BENEFITS **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only ❑ Yes ❑ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

❑ Temporary total disability ❑ Temporary partial disability ❑ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

❑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

❑ D. MEDICAL ONLY INJURY **(No indemnity benefits are due and/or have NOT been controverted.)**

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Section B: completed when indemnity benefits are paid. Section C: completed when claim is controverted. Section D: completed when no indemnity benefits are due and/or have NOT been controverted. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics. Further, this panel shall include one minority physician, whenever feasible. (See Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change of doctor, from the list, may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, NW
Atlanta, Georgia 30303-1299
404-656-3818 or 1-800-533-0682
http://www.ganet.org/sbwc/

The insurance company providing coverage for this business under the Workers' Compensation Law is:
ACCG Insurance Company
PO Box 922608
Norcross, GA 30071
1-877-421-6298

MEDICAL PROVIDERS

Bruce Nixon, M.D.
Longstreet Clinic Neurosurgery
Neurosurgeon
1240 Jesse Jewell Pkwy. SE, Suite 300
Gainesville, GA 30501
(770) 533-7288

Piedmont Regional First Care
Occupational Medicine
485 Hwy. 29 N.
Athens, GA 30601
(706) 353-9300

NGPG Urgent Care Braselton
Urgent Care
1515 River Place, #100
Braselton, GA 30517
(770) 848-6195

Jesse E. Seidman, M.D.
Academy Orthopaedics
Orthopedics, Foot/Ankle
3929 Carter Road
Building C
Buford, GA 30518
(770) 271-9855

Snehal Dalal, M.D.
OrthoAtlanta
Orthopedics, Hand/Upper Extremity
771 Old Norcross Road
Suite 390
Lawrenceville, GA 30046
(678) 957-0757

Robin R. Armenia, D.O.
Occupational Medical
West Jackson
6194 HWY 124
Hoschton, GA 30548
(770) 848-9315

James Duckett, M.D.
Academy Orthopaedics
Orthopedics, Knee/Shoulder/Hip
3929 Carter Road
Building C
Buford, GA 30518
(770) 271-9855

Douglas Kasow, M.D.
OrthoAtlanta
Orthopedics, Spine
771 Old Norcross Road
Suite 390
Lawrenceville, GA 30046
(678) 957-0757

Peidmont Regional 1st Care
340 Exchange Boulevard
Bethlehem, GA 30620
(678) 963-7171

I _____ have selected the above circled physician for my work related injury.
(Date of Injury_____)

_____
Employee Date

_____
HR Representative/Supervisor/Witness Date

(Additional doctors may be added on a separate sheet)

Prepared for: Barrow County
30 N. Broad Street
Winder, GA 30680

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404/656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov.

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. Sec. 34-9-18 and Sec. 34-9-19).
WC-P1 (7/200 (01/06)

Panel Updated 11/06/2018

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. **If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.**

2. **Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.**

3. **Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.**

4. **You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.**

5. **Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $575 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.**

6. **In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $575 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $383 per week, not to exceed 350 weeks.**

7. **When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $383 per week for no longer than 350 weeks.**

8. **Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $575 per week. A widowed spouse with no children will be paid a maximum of $230,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.**

9. **If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.**

Employee's Responsibilities

1. **You should follow written rules of safety and other reasonable policies and procedures of the employer.**

2. **You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.**

3. **An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.**

4. **No compensation shall be allowed for an injury or death due to the employee's willful misconduct.**

5. **You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.**

6. **A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.**

7. **You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.**

8. **If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.**

9. **If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.**

10. **Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.**

11. **If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.**

12. **You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.**

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

******Attention Injured Worker******

The information below must be provided to the Treating Physician or Facility.

DO NOT give them your personal insurance information

Employer		**Workers' Compensation**
Barrow County Board of Commissioners 30 North Broad Street Winder, GA. 30680 Phone: 770-307-3000 Fax: 770-307-3141		ACCG P.O. Box 922608 Norcross, GA 30010 1-877-421-6298
Kristi Carey 770-307-3114	Michelle Thrasher 770-307-3114 ext 5798	

ExpressComp

Temporary Prescription Services ID

Important Benefit Information

Attention Injured Worker:

The attached injured worker prescription instructions identify you as a participant of ExpressComp Program. It is important when filling prescriptions that you present this Temporary Prescription Services ID form to your pharmacist before obtaining your prescription. If you have any questions about your injured worker drug program or to locate a participating pharmacy, please contact Express Scripts toll-free at **1-800-945-5951.**

NOTICE TO INJURED WORKER
This injured worker Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s).

ACCG-GSIWCF

Express Scripts ExpressComp Authorization for Prescription Services
9 digit ID number, pre-printed group number, and date of birth are required fields to process on-line.

ID # _____
Social Security Number here

DATE OF INJURY: _____

DATE OF BIRTH: _____

_____
NAME: FIRST MI LAST

GROUP # AG7A

EMPLOYEE MAILING ADDRESS

_____
STREET

_____
CITY **STATE** **ZIP**

EMPLOYER NAME: Barrow County Board of Commissioners

CONTACT NAME: Kristi Carey 770-307-3114 ext. 3114 or
Michelle Thrasher 770-307-3114 ext. 5798

DEPARTMENT: Human Resources

Help Desk: This is a POS program through Express Scripts only. For assistance call the Express Scripts Help Desk at toll-free number 1-800-945-5951.

Attention Pharmacist:

The ACCG-GSIWCF injured worker prescription benefit program is administered by Express Scripts. The following are the steps necessary to submit a claim.

***Please note**: if the injured worker is filling a prescription for an exposure incident, please fill under the group # "HEALTH"

Please follow the action steps listed below to enter the claim.
Be sure you are using NCPDP version 3.2 allowing for faster service.

	For Non-Exposure Medications	**For Exposure Medications**
Step 1	Enter Bin Number 003858	Enter Bin Number 003858
Step 2	Enter Processor Control A4	Enter Processor Control A4
Step 3	Enter the Group Number as it appears above: **AG7A**	Enter the Group Number as it appears above: **HEALTH**
Step 4	Enter the injured worker's 9 digit ID#: XXX-XX-XXXX	Enter the injured worker's 9 digit ID#: XXX-XX-XXXX
Step 5	Enter first name & last name	Enter first name & last name
Step 6	Enter the injured worker's date of birth as it appears above	Enter the injured worker's date of birth as it appears above

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim,

Workers' Compensation Employee Responsibilities

If an employee sustains an injury on-the-job he/she must at the time of the injury notify his/her supervisor and complete a 1st Report of Injury. All employees must submit to a drug test within eight (8) hours of the injury.

Reporting Injury, Drug Test, and Exam

An employee who sustains an injury on-the-job must, at the time of the injury, notify his/her supervisor on the forms prepared and provided by the Human Resources Department. The employee must also submit to a drug test within eight (8) hours of the injury. The employee must, upon request, submit a physician's statement, from a physician who is listed on the worker's compensation approved panel of physicians, to the effect that the injury will prevent the employee from working. The County shall reserve the right to refuse payment of medical services for any employee examined by a physician not listed on the workers' compensation approved panel of physicians

If your injury requires you to be seen by one of the panel physicians you must contact the Human Resources Department to schedule your appointment. If your injury is after 5pm and you need to be seen by a physician or if it is during normal business hours (8am to 5pm) and is a life threatening injury PLEASE go directly to the nearest emergency room.

It is your responsibility **to report your injury IMMEDIATELY to your supervisor.**

It is your responsibility **to submit to a drug test within eight (8) hours of the injury.**

It is your responsibility **to submit all documents to the Human Resources Department, your Director or Elected Official regarding all further follow up visits that you may need.**

It is your responsibility **to submit a written notice from the physician to the Human Resources Department, your Director or Elected Official if you have been placed on any type of restrictions, limitations or light duty for the duration of treatment.**

It is your responsibility **to submit a written release from the physician to the Human Resources Department, your Director or Elected Official once you are able to return to work fully with no limitations or restrictions.**

If you are seen by at a Physician's Office, Clinic or Hospital, DO NOT give them your personal health insurance card. All Claims must be sent to ACCG.

If you receive an invoice/bill from provider YOU must bring it in to Human Resources to insure prompt payment.

We recognize that our employees are valued and we are committed to assist you in any way that we can with the Workers' Compensation process. Our objective is to see that you receive proper treatment during your work related injury and to help you recover as soon as possible.

ACCG has published a Workers' Compensation Q&A handbook and they are available in our office to help you with questions that you may have.

Thank you,
Barrow County Human Resources Department

Barrow County Accident Review and Recommendation Report

Department/Division		Location		
Exact location of accident:	On premises	Date of occurrence:	Time ☐ Am ☐ PM	Date Reported:
Name of injured:	Date of Birth:	Social Security #:		
Address		Phone:		
Part of body afflicted:				
Nature of injury:				
Object, Equipment, Substance or Task inflicting injury or illness:				

DESCRIPTION

Describe clearly how the accident occurred:			
Did injured see a Dr?	Date	Time AM PM	
Doctor:			

Supervisor

Were Safety Rules Followed? YES ☐ NO ☐ Explain Below	Was the employee in the scope of their Job Duties? ☐ YES ☐ NO	
Recommendation/Prevention:		
Supervisors Name (Please Print)	**Supervisor's Signature** (Please Print)	**Date**
Employee Name (Please Print)	**Employee Signature** (Please Print)	**Date**

*This report is only to be used as an investigation into the accident that occurred. In no way are we investigating an Injury. This form is to be used as a safety investigation and prevention tool ONLY.