CLAYTON COUNTY PUBLIC SCHOOLS
WORKERS COMPENSATION CLAIM FORMS

Remain with the Bookkeeper, Supervisor or Designee until the claim process is complete!

Read This Before You Continue

When an injury or accident occurs on the job, an employee must immediately notify his/her supervisor. The employee then has the opportunity to file a claim. If the employee wishes to file a claim, **injuries will require a drug test to be administered within two (2) hours of the reported injury.**

Employees will not be forced to submit Workers Compensation Claims if they do not wish to do so. **However, if the employee refuses to complete the required claim documents the bookkeeper, supervisor or designee MUST** then at that moment send an email to the Risk Management Team (Leslie Harris, Latasha Lowe and Stephanie Cosby) with the employee's name and ID advising that the employee was offered the opportunity to file the claim but declined/refused (conversation details should be provided where possible).

Clayton County Public Schools

Type: Regulation

Descriptor Code: GAMA-R (1)

Title: Drug-Free Workplace - Workers' Compensation Injuries

Status: ADOPTED

All Workers' Compensation injuries will require a drug test to be administered within two (2) hours of the reported injury. The results of any testing are confidential as provided by federal or Georgia laws. Positive results will be addressed in accordance with the guidelines of Board policy GAMA - Drug-Free Workplace. Refusal to submit to a drug test shall be considered a positive and will result in the denial of the injury claim. Additionally, the refusal may lead to appropriate disciplinary action, up to and including termination.

Prior to submitting this claim it is suggested that you read and understand Regulation GAMA-R (1) Drug-Free Workplace - Workers' Compensation Injuries embedded above and Policy GAMA – Drug Free Workplace provided at the end of this claim packet. Regulations and Policy Documents are available to all Clayton County Public Schools Employees via the Districts Website.

Once a Workers Compensation Claim has been submitted to The Office of Equity and Compliance, Risk Management You Will Be Authorized to report to the clinic for a Drug Test and any requested medical care. Even where you don't want immediate medical care you will still be sent for the Drug Test.

Please Read all forms before you sign them, and answer all questions legibly. **Your responses must be detailed and complete. Please be sure to sign and date all forms where indicated. You must remain with the Bookkeeper, Supervisor or Designee until the claim process is complete and you have been authorized to report to the/a clinic. Do not report to the clinic until authorized.**

If you have questions you are encouraged to seek clarification prior to submitting the written claim by emailing Leslie.Harris@clayton.k12.ga.us **and Copy** Latasha.Lowe@clayton.k12.ga.us **&** Stephanie.cosby@clayton.k12.ga.us **or via phone at 770-473-2738, your Supervisor or Bookkeeper may assist you with reaching out.**

I hereby affirm that I have read and understand the information above.

Signature of Employee Date Month/Day/Year

Clayton County Public Schools
Workers Compensation Claim Process

Once the claim has been submitted to the Risk Management Department the bookkeeper, supervisor or designee must assist with facilitating the entire claims process or designate someone to assist in their absence.

1. If you wish to file a Workers Compensation Claim, you must immediately report the injury to the supervisor or designee on the date it happens when it occurs.

2. The employee or administrator should use their best judgment and seek emergency care where/if needed. Once the emergency has passed the employee will be required to follow-up with a physician from the posted panel.

3. Once the injury has been reported, the bookkeeper, supervisor or designee will provide the employee with the Workers Compensation Claim Packet which is available to all employees via the CCPS District Website. The forms are located via the Department of Equity & Compliance << Risk Management << Workers Compensation.

4. **The employee should take time and care reading each document, answering all questions and selecting a clinic from the posted panel of physicians for treatment. The definition of a posted panel is provided on page 9.**

5. Once the injury has been submitted to Risk Management via the written claim forms, **any Refusal to submit to a drug test shall be considered a positive and will result in the denial of the injury claim.** The refusal will then be reported to the office of Legal Compliance. **Additionally, the refusal may lead to appropriate disciplinary action, up to and including termination per Regulation GAMA R (1) as provided on page 1.**

6. The employee must remain with the, bookkeeper, supervisor or designee after the claim has been submitted, Do Not allow the employee to go back to their office or work site. The claims documents will be reviewed and once verified as complete the employee will be authorized to report to the clinic where the claim has been accepted.

7. The bookkeeper, supervisor or designee will be contacted where corrections, additional information or clarification is needed to the claim submission. Incomplete documents may delay processing and authorization.

8. Authorization will be provided via email to the injured employee whenever possible. The bookkeeper, supervisor or designee will be copied. In some cases, authorization will be given verbally via phone to the bookkeeper, supervisor or designee. The employee should not attempt to seek care at a posted panel clinic/physician without authorization, the clinic will not treat you without prior Authorization.

9. Once Authorized you are required to immediately Report to The Clinic for The Drug Test and any requested care. The Clinic Staff will be expecting you. **Do Not Leave the Clinic Until Your Drug Test Is Complete.** Failure to follow the collector's instructions and/or failure to remain at the testing site/clinic until the drug test is complete will be considered a refusal. You must follow the instructions/protocols of the clinic/staff. Remember, while at the clinic, **a Refusal to submit to a Drug Test shall be considered a positive and will result in the denial of the injury claim, additionally, the refusal may lead to appropriate disciplinary action, up to and including termination per Regulation GAMA R (1).**

10. *If the claim is being reported late in the day or after hours, the employee is encouraged to select a clinic that is open and available to treat the reported injury.* ***The claim packet must still be submitted via email in its entirety.***

11. *Where the employee submits the written claim to Risk Management and opts not to seek medical treatment, selects a clinic that requires an appointment or selects a clinic that is closed, they will be sent to a Concentra Clinic for the Drug Test. Any care requested from a closed clinic or one that requires an appointment will be scheduled as soon as practicable.*

12. After the employee has completed the claim packet, it is preferred that the bookkeeper, supervisor or designee scan the documents to the **Risk Management Team** Leslie.Harris@clayton.k12.ga.us, Latasha.Lowe@clayton.k12.ga.us **&** Stephanie.cosby@clayton.k12.ga.us. If you are unable to scan the documents, please fax them to 770-472-8471. Business hours are 8am-5pm, do not fax forms during non-business hours.

I hereby affirm that I have read and understand the information above.

Signature of Employee Date Month/Day/Year

CLAYTON COUNTY PUBLIC SCHOOLS
WORKERS COMPENSATION CLAIM FORM

Please Write Legibly and **Answer All Questions, Incomplete Forms May Delay Authorization of Care**
Scan the Entire Workers Compensation Packet, Pages 1-9 to the Risk Management Team/Department:
Leslie.Harris@clayton.k12.ga.us and Copy Latasha.Lowe@clayton.k12.ga.us & Stephanie.cosby@clayton.k12.ga.us
Only FAX the Forms to 770-472-8471 when unable to scan

Today's Date Month/Day/Year:	**Employee ID #:**	**Gender: Male □ Or Female □**
First Name:	**Last Name:**	**Date of Birth** Month/Day/Year:
Home Address:	**City:**	**State:** / **Zip:**
Home phone #:	**Cell phone #:**	**Work phone #:**
Work Location:	**Supervisors Full Name:**	**Personal Email Address:**
Job Title:		**Scheduled Lunch Break** (Start time to End time):
Shift Hours (Start time to End time):		**Employment Status:** Full Time □ Part Time □ Substitute □

Date of Injury - *Month/Day/Year*: **Time of Injury: _____ AM □ Or PM □**

1. Did you immediately report this injury to your supervisor/designee? Yes □ or No □ *If "yes" who did you report it to?*

2. Do you understand that a drug test will be mandatory on all claims of injury submitted to Risk Management, even if you opt not to seek medical care? Yes □ or No□

3. Do you wish to seek medical treatment for your reported injuries? Yes □ or No□

4. If You Do Not Wish to Seek Medical Treatment, you must explain why not?

5. Where were you when the injury occurred, **be exact** (list building/site and location inside building/site)?

6. List All the Body Parts That Were Injured & *Circle left or right side where appropriate. For Example:* (*Left*) *Leg*

1. Left or Right	2. Left or Right	3. Left or Right	4. Left or Right
5. Left or Right	6. Left or Right	7. Left or Right	8. Left or Right

7. Have You **EVER** had **any injury or medical condition** to the body parts listed above? Yes □ or No □ - If Yes, explain What, When, Where, How and to What Extent? *If you need additional space for your explanation, please see the attached addendum page4.*

8. Are you **currently** treating with a physician for any of the body parts that you listed above?

9. List the Full Name of any Adult Witnesses below.

1. 2. 3.

10. You must be detailed and clear with your explanation of how you were injured. **Thoroughly Explain** how your injury occurred and tell us what you were doing. Also explain the type of injury sustained to the body part/s listed above. *If you need additional space for your explanation, please see the attached addendum page 4.*

I hereby affirm that I have read and understand the information above. My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Employee Date Month/Day/Year

CLAYTON COUNTY PUBLIC SCHOOLS
WORKERS COMPENSATION ADDENDUM PAGE

First Name:	Last Name:	Employee ID #:

All Workers Compensation Claims of Injury Submitted to Clayton County Public Schools require a Drug Test be administered within 2 hours of an injury per Regulation GAMA R (1).
If you answered "No" to #1 on page 3, you must answer the questions below.

1. Did you know that **you must report** injuries to your supervisor immediately, if yes who explained this to you and when did they tell you?

2. **If you did not report** this injury to your supervisor **on the day that it occurred at the time that it occurred,** please explain why not?

Additional space is provided below for further information/explanation where/when needed

I hereby affirm that I have read and understand the information above. My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Employee

Date Month/Day/Year

CLAYTON COUNTY PUBLIC SCHOOLS WORKERS COMPENSATION WITNESS FORM

Please Write Legibly and Answer All Questions, Incomplete Forms May Delay Authorization of Care

Write NA Across the Middle of the Form If There Is No Adult Witness to The Injury

Only provide adult witness statements. Children/Students cannot provide witness statements.

Witness Information

Today's Date Month/Day/Year:	Employee ID #:		
First Name:	Last Name:		
Home Address:	City:	State:	Zip:
Home phone no.:	Cell phone no.:	Personal Email Address:	
Your Job Title:	Your Work Location:	Supervisors Full Name:	

Information Related to The Incident That You Witnessed

Injured Employees First & Last Name:

Date of Injury *Month/Day/Year*: Time of Injury: _____ AM □ Or PM □

1. Where were you in relation to the employee when the accident occurred?
(location and distance from the accident and/or the employee)

2. What were you doing at the time of the injury?

3. **In detail**, describe what you saw or what you heard? *If you need additional space, please sign, date and attach additional statement.*

4. What assistance did you provide?

5. Who did you notify of the incident, list the first and last name below?

1. **2.**

6. Any additional comments or information you wish to provide:

I hereby affirm that I have read and understand the information above. My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Witness Date Month/Day/Year

CLAYTON COUNTY PUBLIC SCHOOLS
MEDICAL HISTORY FORM

First Name:	Last Name:	Employee ID #:

1. Have you **ever** had or been treated for **ANY** of the following conditions or diseases? **If yes, list the body part/s to the right**

↓Circle "Y" FOR YES OR "N" FOR NO↓

Amputation	Y	N	Herniated/Slipped Disk	Y	N
Hip Injury/Surgery	Y	N	High Blood Pressure	Y	N
Arm/Elbow Injury/Pain	Y	N	Hyperinsulinism	Y	N
Arthritis or rheumatism	Y	N	Joint Pain	Y	N
Back Injury/Pain or surgery	Y	N	Knee Injury/Pain or surgery	Y	N
Head Injury/Pain or surgery	Y	N	Multiple Sclerosis	Y	N
Cancer	Y	N	Muscular Dystrophy	Y	N
Cardiovascular Disorders	Y	N	Neck Injury/Pain or problems	Y	N
Cerebral Palsy	Y	N	Parkinson's Disease	Y	N
Compressed Air Sequelae	Y	N	Poliomyelitis	Y	N
Diabetes	Y	N	Pulmonary Disease	Y	N
Epilepsy	Y	N	Rotator Cuff Injury or surgery	Y	N
Foot/Ankle Injury/Pain	Y	N	Ruptured Disc	Y	N
Hand Injury/Pain	Y	N	Shoulder Injury or pain	Y	N
Sickle Cell Anemia	Y	N	Repetitive motion disorders	Y	N
Hearing or vision Loss	Y	N	Tuberculosis	Y	N
Hemophilia	Y	N	Diseased process of the spine	Y	N
Tendonitis/bursitis	Y	N	Broken Bones	Y	N
Heart Disease	Y	N	Chest Pains	Y	N
Do You Wear Glasses	Y	N	Epilepsy, fainting spells or dizziness	Y	N
Surgical removal of disc or spinal fusion	Y	N	Frequent Headache/Dizziness/Migraines	Y	N
Respiratory problems such as asthma, allergies or lung disease	Y	N			
Depression, anxiety, or other diagnosed mental health disorders	Y	N			
Ankylosis immobility for any major weight bearing joints (ankles, knees, hips)	Y	N			
Wrist Problems (including Carpal/Cubital Tunnel Syndrome	Y	N			

2. Have you **ever** been hurt on the job or filed a Workers Compensation(WC) claim? ☐ YES ☐ NO

If yes:

Date(s): _____

Treating physician(s): _____

Body part(s): _____

Do you currently have any open WC claims, if yes explain below:

3. Have you **ever** had surgery? If yes, when and what for?

4. Have you **ever** received a disability or impairment rating from a physician? If yes, when, what for and what % was given to you?

5. Are you on **any** prescription medication? If yes, what medication(s) and for what condition(s) was the medication(s) prescribed?

6. List **any other** pre-existing diseases, condition or impairment which is permanent in nature, OR for which your doctor has indicated physical limitations/restrictions.

I hereby affirm that I have read and understand the information above. My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Employee Signature

Date Month/Day/ Year

Clayton County Public Schools
PHYSICIAN PANEL FORM

THE POSTED PANEL OF PHYSICIANS FOR CLAYTON COUNTY PUBLIC SCHOOLS INCLUDES THE FOLLOWING PHYSICIANS AND MEDICAL FACILITIES

IF PROFESSIONAL MEDICAL CARE OR TREATMENT IS NEEDED, THE EMPLOYEE MUST SELECT ONE OF THE PHYSICIANS OR MEDICAL FACILITIES LISTED BELOW.

You Must Circle **Only One** Selection from The Posted Panel

Injured employees have a right to change their workers' compensation doctor one time throughout the course of their claim without the approval of the State Board of Workers' Compensation, it will require the submission of a WC-200a Form.

FOR IMMEDIATE ATTENTION

Concentra Clinics Occupational Medicine
1500 Mt. Zion Road
Morrow, GA 30260
Mon - Fri: 7:30 AM to 6:00 PM
678-422-8824

Concentra Clinics Occupational Medicine
3580 Atlanta Avenue
Hapeville, GA 30354
Mon - Fri: 7:00 AM to 12:00 AM (Midnight)
Sat - Sun: 10:00 AM to 6:00 PM
404-768-3351

Concentra Clinics Occupational Medicine
688 Spring Street
Atlanta, GA 30308
Mon - Fri: 7:30 AM to 7:00 PM
Sat - Sun: 10:00 AM to 4:00 PM
404-881-1155

For Risk Management USE ONLY

Auth. By: _____

Time: _____

Date: _____

Clinic Contact:

_____

Authorized Via: Phone or Email
Circle a choice

FOR IMMEDIATE ATTENTION

Caduceus Occupational Medicine
7147 Jonesboro Road
Suite 1
Morrow, GA 30260
Mon - Fri: 8:00 AM to 5:00 PM
770-302-6990

Caduceus Occupational Medicine
414 Hwy 155 South, Suite 15
McDonough, GA 30253
Mon - Fri: 7:00 AM to 5:00 PM
678-902-0477

BY APPOINTMENT ONLY

You will be contacted and provided with an appointment once it has been scheduled, which may take several days.

Peachtree Orthopaedic
By Appointment Only
1901 Phoenix Blvd.
Suite 200
College Park, GA 30349
Mon - Fri: 8:00 AM to 5:00 PM
404-355-0743

Back: Dr. Lagenback
Back: Dr. Kelley
Lower Extremity: Dr. Bernot
Lower Extremity: Dr. Lahiji
Upper Extremity: Dr. McCollam

Peachtree Orthopaedic
By Appointment Only
2001 Peachtree Rd
Suite 705
Atlanta, GA 30309
Mon - Fri: 9:00 AM to 5:00 PM
404-425-1043

Back: Dr. Cassinelli
Physical Medicine: Dr. Schiff

BY APPOINTMENT ONLY

You will be contacted and provided with an appointment once it has been scheduled, which may take several days.

Sutton Orthopaedics
By Appointment Only
145 Medical Boulevard
Stockbridge, GA 30281
Mon - Fri: 8:30 AM to 5:00 PM
770-389-8386

General: Dr Carl Sutton, III
Upper Extremity & Hands: Dr. Burke

Neurology South
By Appointment Only
913 Eagles Landing Parkway
Suite 100
Stockbridge, GA 30281
Monday-Friday 10 AM to 5PM
770-474-4875

Neurologist: Dr. Kolanu

Clayton Eye Center Ophthalmology
By Appointment Only
1000 Corporate Center Dr.
Suite 100
Morrow, GA 30260
Mon - Fri: 8:00 AM to 5:00 PM
Sat: 8:30 AM to 12:00 PM (Noon)
770-968-8888

I have read the information provided above and I understand that if I am injured on-the-job, I must visit one of the physicians/medical facilities listed on the panel above. I understand that I must notify my immediate supervisor of my injury. I understand that a Clayton County Public Schools' Workers' Compensation Risk Management Representative must approve/authorize medical treatment. I further understand that if I seek medical treatment from anyone or anywhere other than with an elected physician/medical facility from the posted panel above, that I shall be responsible for my own medical bills. **My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.**

Employee Signature	Date Month/Day/Year

Bookkeeper Supervisor or Designee - Office Use Only Below This Line

Printed Name of Supervisor or Bookkeeper Facilitating Injury Processing

Is Video Footage Available? Yes ☐ or No ☐ **DVR Label:** **Camera:**

Supervisor or Bookkeeper Signature	Date Month/Day/Year

CLAYTON COUNTY PUBLIC SCHOOLS
WORKERS COMPENSATION CHOICE FORM

First Name:	Last Name:	School/Department:
Employee ID #:		Date of Injury:

Below is the State of Georgia Law Regarding the Workers Compensation Act

Under the provisions of the Georgia Workers' Compensation Act, an employee who is disabled in a work-related accident is entitled to weekly Workers' Compensation benefits equal to two-thirds (2/3rd) of the employee's weekly wage up to a current maximum of $675.00) per week. These benefits commence after a 7-day waiting period. Compensation for the 7-day waiting period becomes payable only if the employee is disabled from work for 21 consecutive days. If you decide to change your payment choice, please contact your bookkeeper or designated personnel to complete/sign a new form workers compensation choice form.

If you are unable to work due to a job-related injury, you have three (3) options for income during your recovery. Please read carefully and check the option below that best suits your needs.

On the Day of Injury When the Employee Seeks Treatment: WC Leave with Pay Code 06 - Only use this code on the first day where treatment is sought and authorized during an employees work shift.

You Must Select One Option

Where available, annual leave may only be requested when all sick leave has been exhausted.

1. _____ I elect to use my available Sick Leave for the entire period of my recovery. I understand that I will continue to receive a monthly paycheck with Employee Benefits deducted until all sick leave is exhausted or until I return to work. I will use my Workers Compensation Benefits ONLY if my Sick Leave and Annual Leave is completely exhausted.

Attendance Codes: WC Sick Leave Code 39, WC Annual Leave Code 44 or WC Leave Without Pay Code 29

2. _____ I elect to use Workers' Compensation benefits. I understand that I will not be eligible to use Sick/Annual Leave and that Workers' Compensation benefits becomes available after a seven (7) day wait. I understand that Workers Compensation pays 2/3rd of my salary, up to $675.00 per week. When opting to receive weekly Workers Compensation benefits, I understand that I will need to speak with a HR Benefits Specialist to setup benefit payments in lieu of scheduled payroll deductions.

Attendance Codes: WC Leave Without Pay Code 29

3. _____ I elect to use my available Sick Leave UNTIL Workers' Compensation benefits becomes available after a seven (7) day wait. I understand that Workers' Compensation pays 2/3rd of my salary, up to $675.00 per week. When opting to receive weekly Workers Compensation benefits, I understand that I will need to speak with a HR Benefits Specialist to setup benefit payments in lieu of scheduled payroll deductions.

Attendance Codes: WC Sick Leave Code 39, WC Annual Leave Code 44 or WC Leave Without Pay Code 29

Where overpaid via the Clayton County Public Schools payroll department, I authorize Clayton County Public Schools to recoup any overpayments where It is verified that I have received a payroll check in error, where at the same time receiving weekly Workers' Compensation Benefits.

I hereby affirm that I have read and understand the information above. My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.	
Employee Signature	Date Month/Day/Year

Bookkeeper Supervisor or Designee - Office Use Only Below This Line

Printed Name of Supervisor or Bookkeeper Facilitating Injury Processing

List Where The Panels Are Posted In Your Building:

Supervisor or Bookkeeper Signature	Date Month/Day/Year

Pause & Read Before Claim Submission

Check Your Workers Compensation Claim Documents to Be Sure That Your Submission is Accurate and Complete

Upon submission of this WC claim to Equity and Compliance Risk Management You Will Be Mandated/Required to report for a Drug Test along with any requested care.

Prior to submitting this claim it is suggested that you review CCPS Policy GAMA Drug Free Workplace which advises that The Georgia Drug-Free Public Work Force Act of 1990 applies to the Clayton County School System.

The Board of Education declares that the manufacture, distribution, sale or possession of controlled substances, marijuana and other dangerous drugs in an unlawful manner or being at work under the influence of alcohol, controlled substances, marijuana or other dangerous or illegal/unlawful drugs is a serious threat to the public health, safety and welfare. With this in mind, the Board declares that its work force must be absolutely free of any person who would knowingly manufacture, distribute, sell or possess a controlled substance, marijuana or a dangerous or illegal/unlawful drug in an unlawful manner. This prohibition specifically includes, but is not limited to, the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance or alcohol in the employee's workplace. This prohibition also includes, but is not limited to, an employee being under the influence of alcohol or controlled substances while on duty.

If you have questions or need clarification on any information provided via this Workers Compensation Claim Packet, please call 770-473-2738.

Please review page 7 to make sure that you have made a selection from the posted panel of physicians.

A Posted Panel of Physicians *is a list of physicians that workers are required to visit for treatment if injured on the job.*

In Georgia, employers are required to post a "Panel" of physicians which is accessible to all employees. The current panel shown on page 7 of this claim packet is posted in several locations at your work site and your bookkeeper or supervisor can direct you to a copy. In order for the "Panel" to be valid, the law in Georgia requires the following:

1. Contain a minimum of six physicians with their name address and phone number listed.
2. Of the six at least one should be an Orthopaedic physician
3. No more than two of the physician groups should be "industrial" clinics

The current panel of Physicians is Lime Green in Color and dated 9-01-2018. A worker injured on the job must select a doctor from the list of posted physicians on the panel. You may not seek care with your personal physician for treatment to an on-the-job injury. **Should you choose to seek care from a doctor not on the approved list, this is considered unauthorized treatment, and CCPS/your employer will not be responsible for the cost associated with this medical care. In addition, most health insurance policies will not pay for medical treatment associated with an on-the-job injury. If you have questions, please contact the state board of worker's compensation at 404-656-3818. Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties up to $10,000.00 per violation** (O.C.G.A. 34-9-18 and 34-9-19).

It is suggested that employees maintain a file, keeping copies of these claim documents along with any/all documents/emails that you receive throughout the life cycle of your claim.

I hereby affirm that I have read and understand all the information related to the submission of this 9 page Workers Compensation Claim of Injury.
My signature certifies that all facts and representations made by me are true, accurate and made willingly and intentionally.

Signature of Employee Date Month/Day/Year