Always Submit All Pages Ordered 1-7 Answer All Questions Ensuring They are Complete

Clayton County Public Schools
Workers' Compensation Claim Process

The employee must remain with the supervisor or bookkeeper until the workers' compensation claim has been processed.

Never send an employee to a clinic without authorization.

When an injury related to the job occurs, an employee must immediately notify their supervisor.

If the employee wishes to file a claim, all workers' compensation injuries will require a drug/alcohol test within two (2) hours of the injury occurrence.

If you have questions, please contact:

Leslie Harris **Leslie.Harris@clayton.k12.ga.us**	**Stephanie Cosby** **Stephanie.Cosby@clayton.k12.ga.us**	**Latasha Lowe** **Latasha.Lowe@clayton.k12.ga.us**
Office: 770-473-2738	**Office: 770-473-2752**	**Office: 678-817-3086**
District Cell: 404-450-7977	**District Cell: 470-345-9133**	**District Cell: 770-238-9165**

Department Fax: 770-472-8471

Please read all forms before you sign and date them.

Your responses must be detailed, complete, and legible.

Never force an employee to file a claim!

Once This Claim Has Been Submitted

to the Risk Management Unit of the Equity and Compliance Division

THE EMPLOYEE WILL NOT BE ALLOWED TO WITHDRAW IT.

The employee will then be REQUIRED to complete a timely, MANDATORY drug/alcohol test on accepted claims. Additionally, the claim will be filed with the GA State Board of Workers' Compensation. See CCPS Board Regulation GAMA-R (1).

All Workers' Compensation injuries will require a drug/alcohol test to be administered within two (2) hours of the reported injury. Once this claim has been accepted, the employee will be authorized to report to their chosen panel physician. When an employee selects a clinic that is "BY APPOINTMENT ONLY," it may take a few days. In the meantime, the employee will be sent to a designated clinic for the drug/alcohol test, where immediate medical care will also be made available until an appointment is arranged with their physician of choice.

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WC Claim Form

1. Date the injury occurred: (MM/DD/YYYY):	**2. Time the injury occurred: _____:_____ Circle AM or PM**	
3. Your Employee ID Number:	**4. Circle Your Gender: Male or Female**	
5. Your First Name:	**6. Your Last Name:**	
7. Your Home Address:		
8. City:	**9. State:**	**10. Zip:**
11. Your Cell Phone #:	**12. Your Home Phone #:**	
13. Your Work Phone #:	**14. Your Personal Email:**	
15. Your Date of Birth:	**16. Your Shift Time** (start time to end time)**:**	
17. Your Scheduled Lunch Break (start time to end time)**:**	**18. Are you required to remain in the building during your lunch break? Circle YES or NO**	
19. Your Job Title:		
20. Your Department & Location:		
21. Your Supervisor's Full Name (first & last)**:**		
22. Circle Your Employment Classification: Full-Time / Part-Time / Substitute		

23. In the boxes provided below - List ALL the body parts you injured, then Circle left, right, or both

This is an Example: ***Left*** ***Right*** ***Both*** ~~Arm~~

1. *Left / Right / Both* _____	**2.** *Left / Right / Both* _____	**3.** *Left / Right / Both* _____	**4.** *Left / Right / Both* _____
5. *Left / Right / Both* _____	**6.** *Left / Right / Both* _____	**7.** *Left / Right / Both* _____	**8.** Other: _____

24. Have you **EVER** had an injury to any of the body parts listed above or been treated by a doctor for **ANY** body parts listed above? **Circle YES or NO**

25. Please Explain in Detail how you injured the body parts listed above. For example, *where were you, what were you doing, and what happened to cause the injury to the body parts listed above? Also, what was the weather like?*

Continued on next page

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WC Claim Form Continued

Additional Writing Space is Provided Below

Answer ALL Questions

26. Who did you report your injury to and what time?

27. **If you did not** immediately report this injury to your supervisor, why not?

28. Based on today's reporting of this injury, are you scheduled to be off tomorrow?

Circle Yes or No

29. Did you receive and sign the document **"How to Report a Work Injury and File a Workers' Compensation Claim at Clayton County Public Schools"**?

Circle Yes or No

30. Were **Any** Witnesses Present? **Circle Yes or No**

If yes, list their full names below and have them complete page 7 (witness page). Please do not delay submitting this claim if the witness is not available to complete page 7, which can be submitted later.

Witness #1 First and Last Name: _____

Witness #2 First and Last Name: _____

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

Print Employee Name: **Employee ID Number:**

Employee Signature: **Today's Date:**

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WC Medical History Form

GINA DISCLOSURE: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law**, we ask that you not provide any genetic information when responding to this request for medical information**. "Genetic information" includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

1. Have you **EVER** had problems with or been treated for **ANY** of the following conditions or diseases?

↓Circle "Y" FOR YES OR "N" FOR NO↓

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

2. Have you **ever** had any prior surgeries or sought treatment from a healthcare provider for any medical conditions listed above? **Circle** **Yes or No**

If yes, explain:

3. Have you **ever** received a disability or impairment rating from a physician? **Circle** **Yes or No**

If yes, when, what for, and what %?

4. Do you have **Any** pre-existing diseases, conditions, or permanent impairments in which your doctor has given you physical limitations/restrictions? **Circle** **Yes or No** If yes, please explain.

5. **Did you complete** a Medical Questionnaire when hired? **Circle** **Yes or No**

6. Are you required to complete a yearly physical in association with your employment? **Circle** **Yes or No**

7. **Before today**, have you **EVER** filed a workers' compensation claim? **Circle** **Yes or No**

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

Employee Signature: **Date:** **Employee ID #:**

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WC Posted Panel of Physicians Form

WHAT IS A POSTED PANEL OF PHYSICIANS?

A Workers' Compensation Posted Panel lists the authorized treating physicians selected by the employer to treat injured workers. Below is the list of doctors (also posted at your worksite) from whom employees may seek treatment if injured on the job at Clayton County Public Schools. A minimum of six doctors is to be listed, representing six different medical practices. In addition, every employer with more than three employees must post a panel of physicians that contains the names and addresses of at least six unassociated doctors or clinics. The treating doctor of your choice will become your authorized treating physician, supervise your treatment, and liaise with any other approved providers.

You Must Select/Circle Only One Authorized Treating Physician from the Posted Panel Provided Below

THESE MEDICAL CENTERS PROVIDE IMMEDIATE CARE

IMMEDIATE CARE 678-422-8824 **Concentra Occupational Medicine** **Morrow Location** 1500 Mt. Zion Road Morrow, GA 30260 Mon - Fri: 7:30 AM - 6:00 PM Sat: 9:00 AM - 3:00 PM	IMMEDIATE CARE 404-768-3351 **Concentra Occupational Medicine** **Hapeville Location** 3580 Atlanta Avenue Hapeville, GA 30354 **OPEN 24 HOURS** Mon - Fri: 12:00 AM - 11:59 PM Sat - Sun: 12:00 Am - 11:59 PM	IMMEDIATE CARE 404-881-1155 **Concentra Occupational Medicine** **Atlanta Location** 688 Spring Street Atlanta, GA 30308 Mon - Fri: 8:00 AM - 5:00 PM	IMMEDIATE CARE 404-425-1212 **Peachtree Occupational Medicine** **College Park Location** 1901 Phoenix Blvd. Suite 205 College Park, GA 30349 Mon - Fri: 8:00 AM - 7:00 PM

THESE MEDICAL CENTERS WORK BY APPOINTMENT ONLY

The Claims Department will contact you and provide you with an appointment; this process may take a few days; your patience is appreciated.

BY APPOINTMENT ONLY 770-389-8386 **Georgia Bone and Joint** General: Dr. Carl Sutton, III Upper Extremity & Hands: Dr. Burke 145 Medical Boulevard Stockbridge, GA 30281 Mon - Fri: 8:30 AM - 5:00 PM	BY APPOINTMENT ONLY 404-355-0743 **Peachtree Orthopedic** Back: Dr. Langenbeck Back: Dr. Kelley Lower Extremity: Dr. Bernot Lower Extremity: Dr. Lahiji Upper Extremity: Dr. McCollam Sports Medicine: Dr. Kimmerly 1901 Phoenix Blvd. Suite 200 College Park, GA 30349 Mon - Fri: 8:00 AM - 5:00 PM	BY APPOINTMENT ONLY 770-474-4875 **Neurology South** Neurologist: Dr. Kolanu 913 Eagles Landing Parkway Suite 100 Stockbridge, GA 30281 Mon - Fri: 10:00 AM - 5:00 PM	This form replicates the "Posted Panel of Physicians," located in common employee areas throughout your worksite, along with "The Bill of Rights for Injured Workers." If you need help locating these site postings, please see your supervisor or Bookkeeper; they will show you where they are located. They are also posted online on the CCPS Website on the Equity and Compliance web page.
BY APPOINTMENT ONLY 770 626-5340 **Georgia Bone and Joint** Back, Neck, & Spine: Dr. Kessler Joints: Dr. Ballantyne Hip &Knee: Dr. Desai Foot & Ankle: Dr. Henisch 125 Grand Oak Drive Fayetteville, GA 30214 Mon - Fri: 8:30 AM - 5:00 PM	BY APPOINTMENT ONLY 404-425-1043 **Peachtree Orthopedic** Back: Dr. Cassinelli Physical Medicine: Dr. Schiff Sports Medicine: Dr. Kimmerly 2001 Peachtree Rd Suite 705 Atlanta, GA 30309 Mon - Fri: 9:00 AM - 5:00 PM	BY APPOINTMENT ONLY 770-968-8888 **Clayton Eye Center Ophthalmology** 1000 Corporate Center Dr. Suite 100 Morrow, GA 30260 Mon - Fri: 8:00 AM - 5:00 PM Sat: 8:30 AM - 12:00 PM (Noon)	

Changing Your Authorized Treating Physician

If you become dissatisfied with your initial choice of treating physician during treatment, you may select an alternate doctor from the posted panel of physicians listed above. This is called your "**one-time change**." The one-time change will require submission of a WC 200 - a CHANGE OF PHYSICIAN / ADDITIONAL TREATMENT BY CONSENT FORM.

I have read the information provided above about the Posted Panel of Physicians. I have made a selection above by circling my choice. I understand a representative from the Risk Management Unit of the Equity and Compliance Division must authorize my medical treatment. I will be responsible for the medical bills if I seek treatment from anyone **not approved** and **listed** on the panel above. I affirm that I have read and I understand this information. My signature certifies that all facts, selections, and representations I made are true, accurate, and made willingly and intentionally.

Employee Signature: **Date:** **Employee ID #:**

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WC Benefits Choice Form

IF I SUFFER AN ECONOMIC DISABILITY, HOW MUCH WILL MY WEEKLY BENEFITS BE?

You will receive two-thirds of your average weekly wage but not more than $800.00 per week for an accident that occurred on or after July 1, 2023. Please see the GA State Board of Workers' Compensation Bill of Rights for the injured worker posted in your building or online.

WHEN DO I RECEIVE BENEFITS?

You are entitled to **weekly Temporary Total Disability benefits** if you miss more than seven days from work. You will only be paid for the first seven days if you are out more than 21 consecutive days due to your injury. Your first check should be mailed to you within 21 days after the first day of disability.

OR CCPS WILL ALLOW THE USE OF SICK LEAVE DURING YOUR RECOVERY

When you cannot work where you are entitled to weekly Workers' Compensation income benefits, you may use your available Sick Leave instead. Also, you may submit an email request to the Risk Management Unit of the Equity and Compliance Division to use your available Annual Leave if and when all Sick Leave has been exhausted.

You Must Check One Option Below

Please read each option carefully and check the one that best suits your needs. You will always have the right to change your selection but must do so by contacting Leslie Harris (Leslie.Harris@clayton.k12.ga.us), Stephanie Cosby (Stephanie.Cosby@clayton.k12.ga.us) and Latasha Lowe (Latasha.Lowe@clayton.k12.ga.us) on your request which will require the completion of a new WC Benefits Choice Form. If FT or PT employees miss ten or more days from work, they will need to speak with HR Absence Management regarding Leave of Absence.

OPTION 1 _____ I elect to use my available Sick Leave for the entire period of my recovery. I understand that I will continue receiving a monthly paycheck from the CCPS payroll department **until ALL sick Leave is exhausted** or I return to work.
Bookkeeper code 360 WC Sick Leave

I understand that **I will not be paid via the CCPS payroll department if my sick Leave is entirely exhausted**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions. **Code 355 WC LWOP**

OPTION 2 _____ I elect to use my available Sick Leave for the first seven days of my recovery. **I then wish to receive Workers' Compensation Disability Benefits if I cannot return after seven days of lost time.**
Bookkeeper code 360 WC Sick Leave

I understand that **I will not be paid via the CCPS payroll department after seven days of absence**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions. **Code 355 WC LWOP**

OPTION 3 _____ I elect IMMEDIATE use of Workers' Compensation Disability Benefits. I do not want to use any sick leave. I understand that I am entitled to receive weekly Temporary Total Disability benefits if I miss more than seven days from work. I will be paid for the first seven days if I'm out more than 21 consecutive days due to my injury. My first check should be mailed to me within 21 days after the first day of disability.
Bookkeeper code 355 WC LWOP

I understand that **I will not be paid via the CCPS payroll department**. I may need to speak with an HR Benefits Specialist to discuss the status of any scheduled payroll benefit deductions. **Code 355 WC LWOP**

I have read the information provided above. I understand that a representative from the Risk Management Unit of the Equity and Compliance Division must authorize any future changes. I agree that funds must be paid back if I am overpaid for Workers' Compensation Benefits by Georgia Administrative Services or overpaid by Clayton County Public Schools Payroll Department. If I refuse to return any overpayment, I understand that Georgia Administrative Services and Clayton County Public Schools may recoup these funds from future WC benefits and payroll checks. My signature certifies that all facts, selections, and representations I made are true, accurate, and made willingly and intentionally.

Employee Signature: **Date:** **Employee ID #:**

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WC Witness Statement Form

Make Additional Copies Where Necessary

This page should be left blank if there were no witnesses

Adults Only (Students may not complete this form)

STATEMENT FORMS MAY BE SUBMITTED LATER WHEN NECESSARY

The Injured Employee's First and Last Name:

The date of the injury:

The time you became aware of the injury: _____:_____

Circle AM or PM

1. Where did the incident occur, be exact?

2. Please explain in detail what occurred and what assistance **you** provided.

3. Whom did **you** tell that an incident had occurred?

4. Is there any additional information that you wish to provide?

Witness Full Name: **Witness Employee ID Number:**

Witness Home Address: **City:** **State:** **Zip:**

Witness Job Title: **Witness Phone Number:**

Witness Work Location and Supervisor:

MY SIGNATURE BELOW AFFIRMS THAT I HAVE READ AND I UNDERSTAND ALL THE ABOVE INFORMATION. MY SIGNATURE CERTIFIES THAT ALL FACTS, SELECTIONS, AND REPRESENTATIONS MADE BY ME ARE TRUE, ACCURATE, AND MADE WILLINGLY AND INTENTIONALLY.

Witness Signature: **Date:**