

**MARTIN COUNTY SCHOOL DISTRICT**  
**PROCEDURES**

**Risk Management**

Safety

**Worker's Compensation Reporting**

**PURPOSE:** To provide a uniform procedure to effectively communicate worker's compensation Injuries to all necessary parties and departments involved in reporting and filing requirements according to State and District guidelines as well as those requirements of the Third Party Administrator. In addition, this procedure is intended to provide reports to those parties responsible for underwriting the losses and those responsible for preventing a reoccurrence of injuries to other personnel.

**WHO:**

Employee

Principal/Director

**ACTION:**

1. Report all on the job injuries to your supervisor/manager *immediately*.
2. Upon notification of an employee injury, determine one of the following:
  - If *emergency medical treatment* is necessary, go to **SECTION I** for instructions.
  - If *non-emergency medical treatment* is necessary, go to **SECTION II** for instructions.
  - If *no medical assistance or first aid only*, go to **SECTION III**.

**SECTION I – Emergency Medical Treatment**

**WHO:**

Supervisor

**ACTION:**

1. For all emergencies, call 9-1-1.
2. Administer first aid until emergency medical assistance arrives.
3. Designate staff member to accompany injured employee to hospital.
4. Report injury to Risk Management Office immediately.
5. Complete *First Report of Injury or Illness DWC-I* in Excel format or hard copy.

- A. Complete Fields A thru O (see attachment).
  - B. Sign and date form (Field N).
  - C. For employee signature (Field N), type or write “*unavailable for signature.*”
  - D. Require employee’s signature when practical.
6. Complete and sign ***Supervisor’s Accident Report*** Form #27.
  7. Send all completed and signed forms to Risk Management.
  8. Maintain copies of completed forms at respective site.
  9. Provide injured employee with copies of completed forms.

## **SECTION II – Non-Emergency Medical**

### **WHO:**

Supervisor

### **ACTION:**

1. Administer first aid if necessary.
2. Complete ***First Report of Injury or Illness*** DWC-1 in Excel format or hard copy.
  - A. Complete Fields A thru O (see attachment).
  - B. Sign and date form (Field N).
  - C. Obtain employee’s signature (Field N).
3. Provide injured party with copy of First Report of Injury form and the ***Martin County School District Attending Physician’s Return to Work Recommendations*** Form #54 to give to Physician.
4. Direct employee to approved Physician’s office or Urgent Care Center for treatment.
5. Complete and sign ***Supervisor’s Accident Report*** Form #27 when needed – check with Risk Management office if you have questions.
6. Send all completed and signed forms to Risk Management.
7. Maintain copies of completed forms at respective site.
8. Provide injured employee with copies of completed form.

## **SECTION III – No-Medical Assistance/First Aid**

### **WHO:**

Supervisor

### **ACTION:**

1. Administer first aid if necessary.
2. Complete First Report of Injury form in Excel format or hard copy.
  - A. Complete Fields A thru O including Employee’s signature (see attached).
  - B. Sign and date form (Field N).
  - C. Have employee complete and sign ***Professional Medical Care Acknowledgement Statement Form*** #174.
3. Inform employee that signing Form #174 will not relinquish their rights to medical treatment if needed at a later date.
4. Send all completed and signed forms to Risk Management.

5. Maintain copies of completed forms at respective site.
6. Provide injured employee with copies of completed forms.

#### Risk Management Analyst

1. Receives Notice of Injury from supervisor and verifies form is complete.
2. If form is not complete, send form back to supervisor for completion or corrections.
3. If form is complete, fill in remaining fields of the First Report of Injury or Illness received from the principal.
4. Notify Third Party Administrator by telephone, e-mail or fax of any incident where medical attention is required or requested.
5. Send copies of completed forms to Third Party Administrator.
6. Email First Report of Injury and Supervisor's Accident Report (if needed) to Safety Officer for accident investigation (if needed).
7. Maintain copies of forms in Risk Management.
8. Retain no medical assistance/first aid notices of injuries in Risk Management Office.

<b>FIRST REPORT OF INJURY OR ILLNESS</b>		RECEIVED BY CLAIM-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE
<b>FLORIDA DEPARTMENT OF FINANCIAL SERVICES</b> <b>DIVISION OF WORKERS' COMPENSATION</b> For assistance call 1-800-342-1741 or contact your local EAO Office Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953				
<b>PLEASE PRINT OR TYPE</b>		<b>EMPLOYEE INFORMATION</b>		
Name (First, Middle, Last)		Social Security Number	Date of Accident	Time of Accident
A		B	C	D
Home Address		Employee's Description of Accident (Include Cause of Injury)		
Street/Apt. #: E		G		
City: State: Zip:				
Telephone: Area Code Number				
F				
Occupation	Injury/Illness That Occurred	Part of Body Affected		L
Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F			
I	J	K		
<b>EMPLOYER INFORMATION</b>				
Co. Name:	SCERMP	Federal ID Number	Date First Reported (Month/Day/Year)	
D.B.A.:	Martin County School Board	(FEIN):596000742		
Street:	500 East Ocean Blvd	Nature of Business		Policy/Member Number
City:	Stuart State: FL Zip 34994	Public School System		
Telephone: Area Code Number	772-219-1200	Date Employed	Paid for Date of Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer's Location Address (if different)		Last Date Employee Worked	Will you continue to pay wages instead of Workers' Comp? <input type="checkbox"/> Yes	
M		Returned to Work <input type="checkbox"/> No If Yes, Give Date <input type="checkbox"/> Yes	Last day wages will be paid instead of Worker's Comp. / /	
Street:			Rate Of Pay <input type="checkbox"/> HR <input type="checkbox"/> WK	
City:	State: Zip:		\$ _____ Per <input type="checkbox"/> DAY <input type="checkbox"/> MO	
Place of Accident (street, city, state, zip)		Date of Death (if applicable)	Number of hours per day	
Street:			Number of hours per week	
City:	State: Zip:	Agree with description of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of days per week	
County of Accident:		Name, Address Telephone and Fax of Physician or Hospital		
Any person, who knowingly and with intent to injure, defraud, or deceive any employer or employee, Insurance Company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Florida Statute 817.234. Section 440.105(7), F.S.				
N	Employee Signature (if available)	Date	O	
	Employer Signature	Date	Authorized by Employer <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>CLAIMS-HANDLING ENTITY INFORMATION</b>				
1a <input type="checkbox"/> Case Denied - DWC-12, Notice of Denial Attached		2. <input type="checkbox"/> Medical Only which became Lost Time Case (Complete all info in #3)		
1b <input type="checkbox"/> Indemnity Only Denied Case - DWC-12, Notice of Denial Attached		Employee's 8th Day of Disability / /		
3. <input type="checkbox"/> Lost Time Case -- 1st day of disability / /		Entity's Knowledge of 8th Day of Disability / /		
Date First Payment Mailed / /		Full Salary in lieu of comp? <input type="checkbox"/> YES Full Salary End Date		
AWW		Comp Rate		
Penalty Amount Paid in 1st Payment \$ <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> Death <input type="checkbox"/> Settlement Only		Interest Amount Paid in 1st Payment \$		
Remarks:		Insurer Name : Martin County School Board		
		Claims-Handling Entity Name, Address & Telephone		
INSURER CODE #	Employee's Class Code	Employer's NAICS Code	Employers Mutual, Inc	
9329		611110	700 Central Parkway	
Service Co/TPA Code #	Claims-Handling Entity File #	Stuart, FL 34994		
6060		1-800-431-2221		
<b>ADDITIONAL NOTES:</b>				