Mobile County PUBLIC SCHOOLS

JOB RELATED INJURY PROCEDURE

IF AN ACCIDENT OCCURS

EMPLOYEE MUST CONTACT PRINCIPAL OR SUPERVISOR WITHIN 24 HOURS

PRINCIPAL OR SUPERVISOR will:

1. Provide for the immediate first aid and safety of the injured employee. If there is the possibility that the employee's injury is life threatening, the Emergency Number 911 should be called.
2. Complete Report of Injury/Accident Form (HS-002) for all accidents reported by employees acting within the line and scope of employment.
3. Send the original copy of all Form HS-002 to Health Services, keeping a copy for the school/department's records.
4. Give employee the Treatment Site Form HS-003, the Physician Statement Form HS-004, and the Release of Information Form HS-006 (this form is to be used if treatment is required after work hours).

IF INJURY REQUIRES IMMEDIATE MEDICAL TREATMENT

1. Have employee sign Release of Information Form (HS-006).
2. The Supervisor/Principal or designee will fax Report of Injury/Accident Form (HS-002) and Release of Information Form to the Central Office Nurse at 221-4298 and Human Resources at 221-6237 and call the Central Office Nurse at 221-4296.
3. Send employee to treatment site with Treatment Site Form and Physician Statement Form. *If employee has United Health Care Insurance, the employee must call his/her primary care Physician prior to treatment.*

AFTER EMPLOYEE IS TREATED:

1. Physician Statement Form **MUST** be provided to the Supervisor/Principal or the Central Office Nurse immediately after treatment in order to determine work status.
2. Should the employee seek medical care after work hours, he/she will take the Treatment Site Form and Physician Statement Form to the treatment site. The employee will notify his/her administrator of treatment at the beginning of the next work day.
3. The Employee must provide an additional Physician's Statement for each visit for the duration of the treatment at the beginning of the next work day.
4. The Central Office Nurse will contact treatment site if additional information is required related to this Injury.
5. Central Office Nurse will maintain all records related to the Job Related Injury in the employee's Health File in the Health Services Office and provide Human Resources with proper documentation.

IF EMPLOYEE IS TO MISS DAYS OF WORK:

1. The Central Office Nurse will be notified by the Principal/Administrator or designee and the documentation will be faxed to the Office Nurse.
2. For each payroll period the employee is off work, the school payroll clerk will fax the Continuation of Pay Form (Code 9) to the Human Resources Department at 221-6237. *Do not send Injury Report, Code 9 or medical documentation to payroll.* The school payroll clerk will note the days missed as Pay Code "OTJ-INJ" in Kronos daily. This will be reflected on the Service Report to be sent to the Payroll Department when time sheets are due for each payroll period.
3. The Employee **MUST** be cleared by the Employee Relations Department **PRIOR** to returning to work. An employee who returns to work without proper clearance from Employee Relations should be referred to HR immediately. The Supervisor/Principal may verify clearance by calling at 221-4542 or 4528.
4. Human Resources will send State board of Adjustment Packet to the Employee.

Mobile County PUBLIC SCHOOLS

HS 002 (REV. 6/14)

MCPSS EMPLOYEE REPORT OF INJURY/ACCIDENT FORM

Complete this form immediately for all accidents reported by employees acting within the line and scope of employment.

1. Name of Injured Employee (please type or print) (Last) (First) (MI)	2. Social Security Number	3. Date of Birth	4. Sex _____M _____F
5. Home Address Work: Years on Present Job _____	6. Telephone Number Home Alternate	7. Job Title Years Employed_____ _____Contract (Y/N)	8. Status ____Full Time ____Part Time/Sub
9. School/Department	10. Agency Address: **MOBILE COUNTY PUBLIC SCHOOL SYSTEM** **P O Box 180069 Mobile, AL 36618**		
11. Date of Injury / 12. Time of Injury	13. Date & Time Supervisor Notified	Did Employee continue to work at assigned tasks after accident ____ Y ____ N	
14. Is employee covered by medical insurance? _____ Yes _____ No If yes: _____ Blue Cross/Blue Shield _____ Other Insurance Name:_____	15. Name and address of attending Physician		
16. Name and address of medical facility where treated _____ Hospitalized _____ Outpatient _____ Emergency Treatment	17. City or town where injury occurred	18. Location/place where injured. School/Dept., Be specific, i.e, which classroom, office, where on grounds, etc.	
19. Did Employee seek medical treatment: Immediately During Work Hours After Work Hours			
20. Describe fully what happened to cause the injury or illness.			
21. Describe the injury or illness in detail and indicate the body part(s) affected:			
22. 1 ST Aide/Treatment Employee received:			
23. Were there any witnesses to the injury? _____Yes _____ NO (If "yes", give name, address, and telephone number)			
24. _____ Signature of Injured person	_____ Print Name	_____ Daytime Telephone Number	_____ Date
25. INVESTIGATION OF THE ACCIDENT: TO BE FILLED OUT BY THE ADMINISTRATOR/SUPERVISOR **ONLY** (Attach additional sheets if needed) How did the accident happen? What was the employee doing? _____ Signature of Supervisor	_____ Print Name	_____ Daytime Telephone Number	_____ Date
For Central Office Use Only : Employee Paid For: _____ hrs/days Days Used _____ Date Returned to Work Full Status			

LEAIR FORM 1 adapted for MCPSS

Mobile County PUBLIC SCHOOLS

HS-004

JOB-RELATED INJURY PROGRAM PHYSICIAN STATEMENT

1. Name of Injured Employee (please type or print) (Last) (First) (MI)	2. Social Security Number	3. Date of Birth	4. Sex ____M ____F
5. Home Address	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status ____ Full Time ____ Part Time ____ Contract
9. Treating Physician	10. Agency Address: MOBILE COUNTY PUBLIC SCHOOL SYSTEM P O Box 180069 Mobile, AL 36618		
11. Date of Injury Date Treated	12. Is there a reasonable expectation that employee will be able to return to work _____ Y _____ N	13. If "yes" on item 12, give the date or approximate date of return	

Diagnosis and Probable Cause:

Was This Condition Present Prior To Injury? (circle) Yes No

Condition Is Related To: (circle) Employment Non-Job Accident Other

Treatment Ordered

Follow Up Treatment

14. If the employee can return to work, are there any restrictions on the employee's duties? YES NO

LIGHT DUTY RESTRICTIONS:

Lifting/Carrying	None Allowed	Maximum Pounds Allowed _____
Standing, Sitting, Walking	None Allowed	Maximum Hours or % Allowed _____
Bending, Stooping, Twisting	None Allowed	Maximum Hours or % Allowed _____
Squatting, Kneeling	None Allowed	Maximum Hours or % Allowed _____
Pushing, Pulling	None Allowed	Maximum Hours or % Allowed _____
Climbing	None Allowed	Maximum Hours or % Allowed _____
Reaching	None Allowed	Maximum Hours or % Allowed _____
Use Of Upper Extremities	None Allowed	Maximum Hours or % Allowed _____
Driving	None Allowed	Maximum Hours or % Allowed _____
Environmental Exposure	Heat Cold Moisture	Maximum Hours or % Allowed _____

Other:

Beginning Date _____ Until _____

15. If "no" on item 12, give details for employee not being able to return to work

16.

Signature of Attending Physician	Print Name	Telephone Number	Date
_____	_____	_____	_____

The need for the information in the physician's statement is authorized by our employee and your statements will be strictly confidential. Please fax this Physician Statement the day of treatment to 251-221-6237. If faxing is unavailable, please give this form to the patient to forward to the Employee Relations Supervisor. Please call the MCPSS Employee Relations Department at 251-221-4531 if you have any questions.

Mobile County
PUBLIC SCHOOLS

EMPLOYEE RELEASE OF MEDICAL INFORMATION FORM

TO WHOM IT MAY CONCERN:

I respectfully request and authorize my treating physician, his or her agents and employees and any other medical personnel to furnish to the Board of School Commissioners of Mobile County, its agents or employees, any and all medical reports, and other related information, in his/her or it's custody, possession or control related to any illnesses or injuries that I may have incurred or may incur while employed by the board of School Commissioners of Mobile County which I allege is a Job-Related Injury. I further authorize you, your agents and employees to discuss the contents of such records or reports or other related information and to provide orally, any additional information to be used in processing any Job-Related Injury claims now or in the future.

I hereby release the aforementioned physicians, medical personnel, Board of School Commissioners of Mobile County and any agents, servants and employees of the physicians, medical personnel, Board of School commissioners of Mobile County from any liability, loss and causes of action that may arise now or in the future as a direct or indirect result of or related to this request, and the release, receipt for use of any information that may be provided pursuant to this medical release.

I UNDERSTAND THAT THIS RELEASE DEALS WITH JOB-RELATED INJURIES ONLY.

_____ _____

DATE Employee Signature

_____

School/Department

_____

Witness

HS-003

ATTENTION TREATMENT SITE:

DATE: _____

_____ is an employee of the Mobile County
(name)
Public School System who is to be treated for a Job Related Injury.

The Mobile County Public School System **DOES NOT** have Worker's Compensation. The employee must use his own insurance. Co-Payment requirement varies according to the type of insurance carried by the employee.

If the employee has no insurance, the employee is responsible for payment.

If you have any questions, please contact the MCPSS Office Nurse at 221-4296.

Employee's Insurance Carrier
(Please check one of the following)

_____Blue Cross/Blue Shield (PEEHIP) _____Blue Cross/Blue Shield

_____United Health Care _____Prime Health

_____Southland _____Other_____

Please fax the Physician's Statement to the Office Nurse at 221-4298
If this is an Occupational Health Network Clinic, please see letter below.

Mobile Infirmary Medical Center

Occupational Health Network

CORPORATE IDENTIFICATION CARD

Mobile Infirmary Medical Center
P.O. Box 2144 Mobile, Alabama 36652
(251) 431-5800

Dear Treatment Site:

This letter is to identify the bearer as an employee of the *Mobile County Public School System*, a client of Occupational Health Network. This letter takes the place of the usual "corporate identification card". Thank you for your cooperation and please direct any questions you may have to me.

Sincerely,
Doug Daniel
Provider Liaison
Occupational Health Network

Attention School or Department: This form and the Physician's Statement Form are to be sent to the treatment site with the employee. **If the Employee has Complete Health, he/she must contact his/her Primary Care Physician Prior to Treatment.**

Mobile County PUBLIC SCHOOLS

DIVISION OF HUMAN RESOURCES
JOB-RELATED INJURY PAYROLL CODE 9 FORM

Please fax this form to Employee Relations at 251-221-6237 when employee returns to work or at the end of each payroll period if employee remains off work. Employee Relations will send to payroll for payment processing if approved.

Employee Name: _____

Title: _____

Employee Number: _____

Employing Dept/School: _____ Payroll Code 9

DATE OF INJURY:

In accordance with the agreed upon procedures of the Board Approved Pay-Continuation Procedure, a request is being submitted for continuation of pay during the pay period of _____ through _____ for the following:

Date	Hrs/ Runs	Date	Hrs/ Runs	Date	Hrs/ Runs	Date	Hrs/ Runs
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

TOTAL NUMBER OF DAYS _____ RUNS _____

Submitted by: _____
Administrator of School/Department

Validated by: _____
Office Nurse/Employee Health Program

Reviewed by: _____
Employee Assistance Supervisor

Authorized by: _____
Assistant Superintendent
Division of Human Resources

If you have any questions please call Employee Relations at 251-221-4528 or 251-221-4542.

cc: Employee
Payroll