

Workers' Compensation Claim Worksheet and Employee Responsibilities for Work-Related Injuries

Please read carefully before completing the attached form

In the-event of a work-related Injury or illness, notify your supervisor/principal immediately (within 24 hours when possible) to obtain any medically necessary treatment from an **authorized** provider within the workers' compensation network (see options on claim worksheet). You will need to complete the attached **Employee Workers' Compensation Claim Worksheet**, sign and date, and obtain a supervisor's signature. This form needs to be taken to your department/school secretary for completion of filing a workers' compensation claim.

Treatment for a serious or life-threatening emergency may be received from any emergency facility. Upon release from the ER please proceed to the nearest authorized clinic as soon as possible. ER's cannot refer you to a specialist or your own doctor. Work restrictions/treatment will be addressed at the clinic.

1. A copy of your **Return to Work** form will need to be returned to your supervisor immediately upon returning to work. **Inform your authorized treating physician that there are modified transitional jobs available at your work site or within the school district.** It is your responsibility to contact your school/department, inform them of your restrictions (if any) and confirm light duty is available. **You cannot return to work without a release from an authorized treating physician.**
2. If your authorized treating physician requests additional follow up visits, outpatient testing or physical therapy, you may need to schedule those appointments outside of your normal work day as these absences may not qualify to be paid under workers' compensation. In some instances, specialists' visits may be covered if appointment hours are not available outside your schedule.
3. Your authorized treating physician may authorize any additional needed **specialty** care. **Treatment received without approval from Johns Eastern Company is not covered**
4. Representatives from Johns Eastern will be contacting you to assist you with your claim. Please be sure to take/return their calls.
5. Pinellas County Schools has the right to choose the medical providers who will treat you.
6. Workers' Compensation will also replace part of your lost wages if your authorized treating physician says you must be out of work for a certain length of time because of a work-related injury or illness. It is your responsibility to notify your supervisor or school/department secretary of this action.
7. If you have an illness or injury that requires your absence to extend beyond ten days, contact your school or department secretary and complete a **Request for Leave of Absence**.

Please contact Risk Management at 727-588-6196 if you have any questions.

EMPLOYEE – PLEASE KEEP A COPY OF THIS PAGE

EMPLOYEE WORKERS' COMPENSATION CLAIM WORKSHEET

CLAIM MUST BE REPORTED TO SCHOOL OR DEPARTMENT SECRETARY

Call Risk Management at 727-588-6196 if unable to submit claim or for assistance

EMPLOYEE INFORMATION:

Name: _____ Last 4 digits of SSN: _____

Date of Injury: _____ Time of Injury: _____ Date employer notified: _____

Time shift began: _____ Home Phone: _____ Cell Phone: _____

Was injury on employer's premises? Yes _____ No _____ If no, address where injury occurred: _____

Were you doing your regular job? Yes _____ No _____ Name of School/Dept. _____

EMPLOYEE STATEMENT:

In your own words, please provide full description of accident. Indicate specific Body Part(s) injured—Be specific using "left", "right", "upper", "lower" as clear indicators, i.e. "bruised thumb on right hand":

Body Part(s) Injured: _____

Have you ever sought medical treatment for this body part in the past? Yes _____ No _____

If Yes, when? _____ What type of treatment sought? _____

Witness name/phone number: _____

Is medical treatment requested? Yes _____ No _____

If **Yes** please check the authorized worker's compensation facility below you plan to seek treatment at:

<input type="checkbox"/> Clearwater American Family Care (AFC)	<input type="checkbox"/> New Port Richey (Trinity East) – BayCare Urgent Care
<input type="checkbox"/> Clearwater (McMullen-Booth) - BayCare Urgent Care	<input type="checkbox"/> New Port Richey (Trinity Village) - Suncoast Urgent Care
<input type="checkbox"/> Clearwater (S. Belcher Rd) - BayCare Urgent Care	<input type="checkbox"/> Palm Harbor (US 19) - Doctor's Urgent Care
<input type="checkbox"/> Clearwater (East Ulmerton Rd) - Concentra	<input type="checkbox"/> St. Pete (33 rd St. N) – Concentra
<input type="checkbox"/> Largo (East Bay Dr) - Concentra	<input type="checkbox"/> St. Pete (4 th St. N) - BayCare Urgent Care
<input type="checkbox"/> Largo (Walsingham Rd) - BayCare Urgent Care	<input type="checkbox"/> St. Pete (Tyrone/66 th St)- BayCare Urgent Care
<input type="checkbox"/> New Port Richey (US 19) - BayCare Urgent Care	

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.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Please retain in Employee File. Fax this form to Risk Management (727) 588-6182 upon request only. Determination of compensability of the claim has not yet been accepted and is being investigated pursuant to Florida Statute Chapter 440.