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 Davies (formerly 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":

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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:

__**Clearwater** (McMullen-Booth) - BayCare Urgent Care

__**Clearwater** (S. Belcher Rd) - BayCare Urgent Care

__**Clearwater** (East Ulmerton Rd) - Concentra

__**Largo** (East Bay Dr) - Concentra

__**Largo** (Walsingham Rd) - BayCare Urgent Care

__**New Port Richey** (US 19) - BayCare Urgent Care

__ **New Port Richey** (Trinity East) – BayCare Urgent Care

__ **New Port Richey** (Trinity Village) - Suncoast Urgent Care

__ **Palm Harbor** (US 19) – M D Now

__ **St. Pete** (33rd St. N) – Concentra

__ **St. Pete** (4th St. N) - BayCare Urgent Care

__ **St. Pete** (Tyrone/66th St)- BayCare Urgent Care

__**St. Pete Beach** (Gulf Blvd) –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.