

Dougherty County School System Worker's Compensation Procedures

IMPORTANT! Failure to comply with the following procedures when an on-the-job injury occurs may prevent you from receiving Worker's Compensation Benefits.

1. When an employee is injured at work, the employee must report the injury to his/her supervisor immediately and complete the attached forms. Employees who refuse to sign the Consent to Release Medical Information form shall not be entitled to any compensation or a hearing on such issue.
2. Should an injury require medical treatment, the employee must choose a physician from the list below and receive authorization for treatment prior to seeing the physician. Follow-up visits should be scheduled before or after work hours when at all possible
3. **Worker's Compensation will not pay for treatment at the emergency room in non-emergency situations.**

Panel of Physicians

Drs. T. Glenn Williams, Thomas Darden, Jason Potocki, and Paul Michas 619 Pointe North Blvd. Albany, GA 31721 229.883.4707	Dr. Kimberly Brown 417 W. 3 rd Avenue Albany, GA 31701 229-432-9515	Drs. T. Scott McGee and Duncan Marsh Meredyth Professional Plaza 2405 Osler Court Albany, GA 31707 229.435.1458
Drs. Robert Pilcher and Troy Skidmore 2709 Meredyth Dr. – Suite 450 Albany, GA 31707 229.312.5000	Dr. Thomas Hilsman 2201 Dawson Road Albany, GA 31707 229.883.1368	Dr. Scott Wall 2308 Palmyra Road Albany, GA 31701 229.889.0018
Dr. Craig Murray 910 N. Jefferson Street Albany, GA 31701 229.436.1830	Dr. Kenneth Durham 531 7 th Avenue Albany, GA 31701 229.883.3535	Phoebe East – Corporate Health 2410 Sylvester Road Albany, GA 31705 229.312.9220

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I have read (or have had read to me) and understand that the above procedures are to be followed in the case of an on-the-job injury.

Date:	Employee Name (Print):
Employee Signature:	

IMPORTANT! Disclosure of workers' compensation is exempt from the federal Health Insurance Portability and Accountability Act (HIPPA) privacy requirements.

**Dougherty County School System
Worker's Compensation First Report of Injury**

Section I: Employee's Report of Injury

Employee should complete form as soon as possible after incident. Please answer all questions.

Employee Name: (Last) (First) (M)		SSN:	Date of Birth:	Age:	Male	Female
Home Address:		City:	State:	Zip Code:		
Employee's Home Phone Number:		Number of Dependents Including Spouse:		Family Doctor:		
Work Location:		Job Title:		Hire Date:		
Job Duties:						
Date of Injury:	Time of Injury:	Time Workday Began: AM() PM()		Work Hours: _____ To _____		
Did injury occur while on the job? Yes No		Date Employer Notified:		Did you seek medical help?		
Treating Physician: (Name & Address)		List all part(s) of your body that were injured. Be specific. Denote right or left.				
Where did the accident occur?	How did the accident occur? Be specific. (State what you were doing and name the machine, tool or what caused the injury.)					
Whom did you tell about the accident?			Who saw the accident happen?			
To prevent this type of accident in the future, how could this have been prevented?						
If this injury requires medical treatment, please list any medicines that you are taking (prior to this injury).						
Are you employed with any employer other than the Dougherty County School System?			If yes, give name of employer and duties.			
Employee Signature:			Date:			
Supervisor Signature:			Date:			

**Dougherty County School System
Worker's Compensation First Report of Injury**

Section II: Witness Statement

Injured Employee: (Last) (First) (M)

Full Name of Witness:

Home Phone Number:

Home Address:

City:

State:

Zip Code:

Place of Employment:

Work Phone Number:

How Long?

Job Duties:

How long have you known the injured?

Do you work with injured employee?
Yes No

If Yes, how long?

To the best of your knowledge, state the date and time you became aware that the above employee was injured:

Did you see what happened?

Yes No

What was the cause of the accident?

What part(s) of the employee's body appeared to be injured? Be specific.

Who else saw the accident or has knowledge of it?

Was the accident reported?

Yes No

If Yes, to whom:

Did you think the above employee was injured?

Yes No

Why or Why not?

Why do you think this accident happened?

How could it have been prevented?

Do you know of previous complaints of physical problems by the above employee?

Yes No

If yes, please list:

If you have additional comments or information on this accident, indicate below:

Witness Signature:

Date:

Supervisor Signature:

Date:

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

TO:			RE: Employee / Patient		
Print Name and Title			Last Name	First Name	M.I.
Address			Social Security Number	Date of Injury	Birth Date
City	State	Zip			

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to _____ in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim

It is important to note that disclosure for workers' compensation is exempt from the federal Health Insurance Portability and Accountability Act (HIPPA) Privacy Requirements.

The patient completely releases the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of medical information as authorized herein. This release is in compliance with Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPM) of 1996. 45 CFR 164.512(1) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this document receives the same under all protection of Federal and State law.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee/Patient Signature	Date
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Ref: SBWC-207