Fredericksburg City Public Schools

Worker's Compensation

INFORMATION FOR EMPLOYEES

If you have been injured at work, you should notify your supervisor of your injury or occupational disease (illness) immediately, and utilize the Supervisor's Investigation Report, First Report of Injury Form, and Preferred Provider Panel Consent Form (for emergencies, use any emergency facility) in the packet attached to this cover page.

TYPES OF INJURIES UNDER THE ACT:

Employees are entitled to receive compensation for an "injury by accident" or an "occupational disease."

In order to be covered, an "accident" must:

1. Occur at work or during a work-related function.
2. Be caused by a specific work activity.
3. Happen suddenly at a specific time.
   (Injuries incurred gradually or from repetitive trauma are not covered, although certain diseases caused by repetitive trauma are covered.)

In order to be covered, a disease must:

1. Be caused by the work.
2. Not be a disease of the back, neck, or spinal column.

Fredericksburg Public Schools

817 Princess Anne Street
Fredericksburg, VA 22401-5819
Telephone: (540) 372-1130
Fax: (540) 372-1111

August 2, 2011

MEMORANDUM
PAYROLL DEPARTMENT
11-12

TO: School Secretaries/Cafeterias/Maintenance/Transportation

FROM: Shelda Roach, Supervisor of Payroll/Benefits

RE: **IMPORTANT WORKER'S COMPENSATION INFORMATION**

Attached is a batch of **First Report of Injury Forms** with a **Preferred Provider Panel of Physicians** list, a **Preferred Provider Panel Consent Form** (which **MUST** be completed), and the **Supervisor's Investigation Report**. These forms are to be completed whenever an employee is injured while on the job. Please note the following:

- provide all applicable information
- submit the **First Report of Injury Form** to the Payroll Department **within 24 hours** of the accident, along with the **Preferred Provider Panel Consent Form** and the **Supervisor's Investigation Report**
- indicate on the Service Reports if employee has missed work due to a work related injury by noting the absence with a "WC" (Worker's Comp).
- the **First Report of Injury Form MUST BE signed by whoever submits the form to Payroll.**

Note: Employees who are injured and need to seek medical attention MUST use one of the physicians listed on the Preferred Provider Panel. The employee must be given the packet which includes the First Report of Injury, the Preferred Provider Panel, the Preferred Provided Panel Consent Form and the Supervisor's Investigation Report. Please inform employees who are injured that if they do not elect a Physician on the Panel, the employee may be responsible for the cost of his/her medical care. Also, a copy of the Preferred Provider Panel must be posted at each location. A copy is included with this memo for offices to post.

If you have any questions, please contact our office.

Attachments

Sedgwick CMS

Post Office Box 85631
Richmond, Virginia 23285-5631

THIS REPORT MUST BE TURNED IN BEFORE YOU LEAVE WORK ON THE DAY OF THE ACCIDENT

SUPERVISOR'S INVESTIGATION REPORT

Name _____ **Home phone** _____

Dept. Number _____ **Date of accident** _____ **Time** _____

How long on this job _____ **Shift** _____ **Day of week** _____

First aid given [ ] Yes [ ] No **By whom** _____

Type of first aid _____

_____

Sent to medical facility [ ] Yes [ ] No

Name _____

Address _____

Witness _____

Where did incident occur (exact property location) _____

_____

If injury occurred, describe fully _____

_____

Equipment/action involved _____

_____

What happened _____

_____

Corrective action(s) to prevent a recurrence _____

_____

Check one:

Working _____ **Signed** _____

Lost time _____ **Reviewed by** _____

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for filing: _____
VWC Jurisdiction Claim #: (If assigned) _____
Claim Administrator File#: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Employer's Mailing Address	
Name/FEIN of Entity on Policy	Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number

Time and Place of Accident

Location where accident occurred	Date of injury	Hour of injury ☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death If fatal, give number of dependent children	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness
Describe fully how injury or illness occurred
Describe nature of injury, occupational disease, or illness, including body parts affected

Signatures

Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

Preferred Provider Panel Consent Form

(To be signed by the employee after the accident)

I have reviewed the Panel of Physicians provided to me by my employer and have selected the medical provider listed below to receive medical treatment for my work-related injury.

I understand that if I fail to use one of the recommended medical providers, excepting a medical emergency, I shall be liable for the cost of the medical care as provided for in Section 65.1-89 of the Virginia Workers' Compensation Law.

On calling the provider for an appointment, inform them that the treatment is for a work-related injury and the claims administrator is CompManagement, Inc.

Physician: _____

Address: _____

_____

Telephone No.: _____

Employee Social Security No.: _____

Employee Name: _____

Employer Name: _____

Address: _____

_____

Signature: _____ **Date:** _____

Employee

Please forward the original along with the Employer's First Report of Injury form to:

Fredericksburg City Schools
817 Princess Anne Street
Fredericksburg, VA 22401

ATTN: PAYROLL DEPARTMENT

FREDERICKSBURG CITY PUBLIC SCHOOLS
Fredericksburg, VA 22401

PREFERRED PROVIDER PANEL

Use One of These Physicians for Work Related Injuries

- Notify your supervisor of your illness or injury.
- Tell your doctor that you are under a Worker's Comp program.
- For emergencies, use any emergency facility.
- If you do not use a panel doctor, you may be responsible for the cost of your medical care.

Worker's Compensation Program Administered by Sedgwick Claims Management Services

SELECTED PROVIDER PANEL

EMERGENCY MEDICAL CENTERS

Mary Washington Hospital
1001 Sam Perry Blvd.
Fredericksburg, VA 22401
540-741-1100

Spotsylvania Emergi-Center
992 Bragg Road
Fredericksburg, VA 22407
540-786-7637

Patient First-Central Park
3031 Plank Road
Fredericksburg, VA 22401
540-736-5043

PREFERRED PROVIDER PANEL
WORKER'S COMP
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FAMILY MEDICAL PROVIDERS

Pratt Medical Center
12101 Carol Lane
Fredericksburg, VA 22407
540-785-7778

Rappahannock Family Physicians
120 Executive Center Parkway
Fredericksburg, VA 22401
540-374-5200

OPHTHALMOLOGY

Access Eye Center
3916 Plank Rd.
Fredericksburg, VA 22407
540-786-3900

Access Eye Center
110 Cambridge Street
Fredericksburg, VA 22405
540-371-2020

Brock, Lee R. MD
4304 Lafayette Blvd.
Fredericksburg, VA 22408
540-891-4444

ORTHOPAEDIC PROVIDERS

Center for Orthopedics, Inc.
2201 Charles Street
Fredericksburg, VA 22401
540-371-5333

Fredericksburg Orthopedic Assoc.
3310 Fall Hill Ave.
Fredericksburg, VA 22401
540-373-4602

Orthopedic Specialty Clinic, LTD
2800 Welford Street
Fredericksburg, VA 22401
540-361-1830

PREFERRED PROVIDER PANEL
WORKER'S COMP
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CHIROPRACTIC CLINICS

Bach Chiropractic & Acupuncture
2501 Fall Hill Ave., STE B
Fredericksburg, VA 22401
540-374-0998

Fredericksburg Family Chiropractic
10411 Courthouse Rd., STE B
Spotsylvania, VA 22553
540-891-9191

PODIATRY PROVIDER

Rappahannock Foot & Ankle Specialist
195 Falcon Drive
Fredericksburg, VA 22408
540-371-2724

8/2011