PROCEDURES TO FOLLOW FOR AN ON-THE-JOB INJURY

What to do:

For non-emergency situations:

1. Contact the provider below to make an appointment for the employee.
   The **employer** must make the appointment.

   Lexington Family Physicians
   102 West Medical Park Drive
   Lexington, NC 27292
   Phone: 336-249-3329

   The employee must be seen by this provider or the cost of the visit will not be covered

2. Provide the injured employee with the following forms BEFORE sending the employee to provider:
   a) **LCS Workers' Comp Physician's Report**
   Supervisor must complete the top portion of the form which authorizes treatment. Employee must present form to physician's office. After physician completes the remainder of the form employee should return to the employer.
   b) **Lexington Family Physicians form**
   Employee must complete form. School office must fax form to provider before employee is seen.
   c) **State of NC DPI Workers' Compensation Prescription Information**
   Employee must present this form to the pharmacy.

3. Please notify Carolyn Johnson of the injury immediately. She can be reached by phone at 336-242-1527 x1210 or by email at cjohnson@lexcs.org

For emergency situations: The employee should be taken to the nearest hospital for immediate care.

Return the following W/C forms to Carolyn Johnson within 5 working days from the date of injury:

- LCS Employee Accident/ Injury Report
- Workers' Compensation Leave (signed and dated)
- LCS Attending Physicians Report
- LCS Accident/ Injury Investigation Report
- LCS Workers' Compensation Witness Statement

****Please make sure all fields are completed and signed by the employee and supervisor before submitting.****

OFFICE

LEXINGTON CITY SCHOOLS EMPLOYEE ACCIDENT/INJURY REPORT

Complete this report for employee injury and forward to Carolyn Johnson within 5 days from date of injury

Employee Name: First: Middle: Last:

Address: City: State: Zip:

Soc. Security Number (Last 4 digits): Home Phone: Work Phone:

DOB: Email:

Gender: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced, Widowed, Separated

No. of Dependents: Did injury occur on employer's premises: ☐yes ☐no Location:

Did this injury start away from work? ☐Yes ☐No Did this injury aggravate an existing injury? ☐Yes ☐No
If either answer is yes, please give details.

Date of injury/illness: / / Time of injury/illness: : ☐am ☐pm Date employer notified of injury: / /

Occupation when injured: Time began work on date of injury: : ☐am ☐pm

How did the injury or illness occur? Describe the sequence of events and include any objects or substance that directly injured or made you ill:

Specific activity you were engaged in when accident or illness occurred:

Work process you were engaged in when accident or illness occurred:

Type of injury: Part of body injured:

Cause of injury: Date employer notified: / /

Name of physician seen: Did you receive a prescription from physician? ☐Yes ☐No

Treatment rendered by physician:

Signature of employee: Date: / /

****

SUPERVISOR TO COMPLETE

Employee's time missed from work (list dates):

Do you have any issues or concerns with this claim? If so, please explain:

Signature of Supervisor:
(By my signature I am verifying that this is a valid work-related injury): Date: / /

Workers' Compensation Leave

Eligibility

The provisions of the Workers' Compensation Act are applicable to all school employees. The State is responsible for this compensation to the extent that the employee's salary is paid from state funds. The LEA is responsible for a pro rata share of any locally funded part of the salary, and any federally funded proportion must be paid from federal funds.

Use of Leave During Required Waiting Period

The workers' compensation law provides medical benefits and a weekly compensation benefit equal to 66 2/3 percent of the employee's average earnings up to a maximum established by the Industrial Commission each year. When an employee is injured on the job or contracts an occupational disease, he or she may begin workers' compensation benefits after the required waiting period of seven calendar days. During the waiting period the employee may:

a. Elect to use appropriate earned leave, or

b. Elect to go on leave without pay.

Seven-day Waiting Period

No workers' compensation weekly benefit is allowed for the first seven calendar days of disability resulting from an injury on the job or contracting an occupational disease, except the medical benefits provided for in G.S. 97-25. However, if the injury results in disability of more than 21 days, the compensation will be allowed from the date of the disability. Nothing in this section shall prevent an employer from allowing an employee to use appropriate earned leave or disability benefits provided directly by the employer during the first seven calendar days of disability.

Use of Leave to Supplement Weekly Compensation

In order to provide an income approximately equal to but not exceeding the employee's usual weekly salary, sick and annual vacation leave earned prior to going on workers' compensation may be used while an employee is receiving workers' compensation weekly benefits. For the purposes of supplementing Workers' Compensation, sick and annual vacation leave may be used in whole days or half days. Use of sick and annual vacation leave, regardless of the amount charged to use, shall not result in compensation greater than the usual full salary. Employees receiving workers' compensation benefits are not paid for holidays scheduled in the calendar. Any salary increases are received upon reinstatement

Earning Leave Under Workers' Compensation

While on workers' compensation leave, the employee will continue to earn sick leave, annual vacation leave, and, if applicable, personal leave. Leave earned must be credited to the employee's account for use upon his or her return. If the employee does not return to active employment, a maximum of one year's leave earnings will be added to the employee's leave balance prior to going on workers' compensation leave and accumulated annual vacation leave will be paid in a lump sum to a maximum of 30 days or 240 hours.

Earning Longevity Under Workers' Compensation

While receiving workers' compensation benefits, the employee will continue to earn longevity credit, if applicable. If the employee's anniversary date occurs during the period while the employee is receiving workers' compensation, longevity is paid on the employee's anniversary date. Teachers do not earn experience credit while on workers' compensation, except when they are using sick leave, extended sick leave, personal leave, or any other available paid leave.

Medical Services – Referrals

For non-emergency situations, you must be seen by a physician at MedChoice. You may not change doctors unless you are referred to another doctor by the last treating physician or obtain approval from Key Risk Management Services, Inc. and/or the NC Industrial Commission.

Travel

Employees are entitled to be reimbursed for mileage for medical treatment at the rate of $.31 a mile providing they travel 20 miles or more roundtrip. Form 25T must be completed for reimbursement.

Prescription Drugs

Pink copy of *Medical Authorization and Attending Physician's Report* should be given to pharmacy so that prescription can be filed with Key Risk Management Services, Inc.

Name ______________________ Date of Injury ______________________

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE RULES SET OUT TO BE FOLLOWED IN THE HANDLING OF MY CLAIM.

______________________ ______________________

Signature of Employee Date

OFFICE

LEXINGTON CITY SCHOOLS WORKERS' COMP PHYSICIAN'S REPORT

EMPLOYER: Please complete the top section and give to the injured employee to take with them to their authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee: **Last:**	**First:**
Date of Injury:	
Name of Employer:	
Employer Signature:	Treating Physician:

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The NC DPI Medical Card form is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: ____

A post accident drug test (check one) ( ) has been completed ( ) has not been completed

In accordance with this patient's physical capability, check all that apply:

( ) May resume work immediately, no restriction.
( ) May resume work immediately with the following restrictions:
- ( ) Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
- ( ) Light work (lifting less than 20 pounds)
- ( ) Medium work (lifting less than 50 pounds)
- ( ) Heavy work (lifting less than 100 pounds)
- ( ) Normal shift
- ( ) Limited hours: _____ hrs, ______ hrs, ______hrs per day
- ( ) Other: ____

( ) Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right
No Use		
Occasional <33% of time		
Frequent 34-66% of time		
Regular 67-100% of time		

( ) Patient may return to work at full duty on (date) ______________________
( ) Patient has a return appointment on (date)______________________at (time) __________

Please indicate any referrals that are required:______________________________________

Physician's Signature______________________________**Date** ______________

Physician's Name (type or print) ______________________________

Physician Offices – Be sure to contact Sedgwick Claims Department at 919-785-5800 for authorizations for referral.

Mail Address:
Sedgwick
P.O Box 14774,
Lexington, KY 40512

LEXINGTON CITY SCHOOLS ACCIDENT/INJURY INVESTIGATION REPORT

(Supervisor to Complete)

Employee Name: First: Middle: Last:

Date of injury/illness: / / Occupation when injured:

Brief description of accident/injury (attach copy of Employee Accident/Injury Report):

****

CAUSES OF ACCIDENT/INJURY

Circle or write in all that apply

Environmental Factors	Work Conditions	Personal Factors	Job Factors	Management Issues
Weather conditions (specify:_________) Heat Cold Noise Smoke/fumes Dust Third party	Poor housekeeping/ clutter Defective equipment Inadequate workspace Uneven/wet walking surface Inadequate protective equip. Inadequate lighting Inadequate ventilation	Unsafe physical condition Unsafe act Carelessness Lack of knowledge/ skill Lack of training Improper motivation Inadequate planning Fatigue/stress Deviation from procedure Violation of safety rule	Inadequate design Inadequate equip./tools Inadequate procedures Inadequate maintenance Inadequate inspection Inadequate purchasing	Insufficient training Inadequate planning Lack of program support Lack of enforcement Budgetary constraints Understaffed
Other:				

****

CORRECTIVE ACTION

Fill in all that apply

	Description of corrective action to be taken	Assigned to	Date completed
Immediate			
Short Term			
Long Term			

Investigation COMPLETED by: Date:

Investigation REVIEWED by: Date:

LEXINGTON CITY SCHOOLS
WORKERS' COMPENSATION WITNESS STATEMENT

______________________________ listed you as a witness to a workers' compensation accident on ____________. Please list below what you witnessed regarding when, how, and where accident occurred and injuries received.

____

____

____

____

____

____

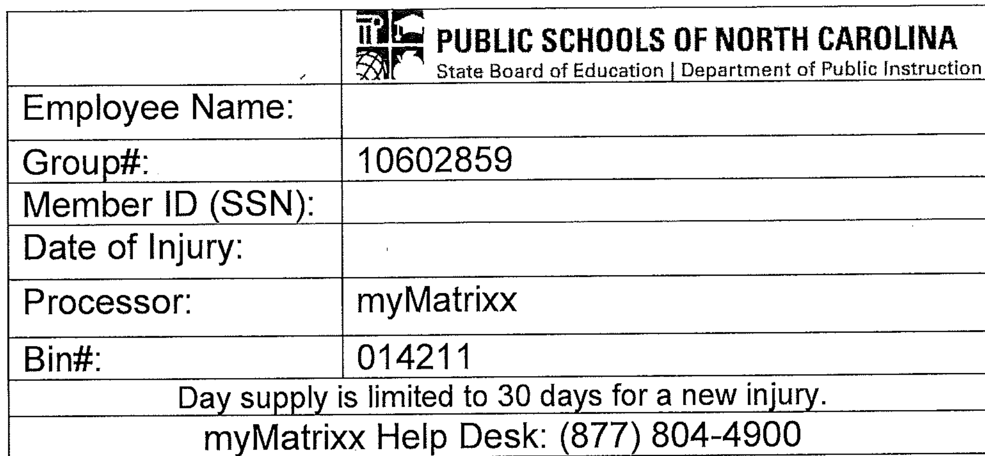
____

______________________________ Witness Signature

________________ Date

State of North Carolina Department of Public Instruction
Workers' Compensation Prescription Information

Employer:
Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.



	PUBLIC SCHOOLS OF NORTH CAROLINA State Board of Education | Department of Public Instruction
Employee Name:	
Group#:	10602859
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:
State of North Carolina Department of Public Instruction has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:
Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

LEXINGTON FAMILY PHYSICIANS

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lexington Family physicians or insurance company to release any information required to process my claims.

Patient/Guardian signature ________________ *Date* ________________