

Supervisor Instructions

Workers Compensation

1. Review Informational Overview
2. Sends employee to Business Health for medical evaluation.
 - Advise employee to contact Human Resource upon their release from Business Health
3. Have employee sign Medical Waiver and Consent Form if reasonable for them to sign at the time. If not Human Resources will have them sign upon their return.
4. Notify Human Resources Department.
5. Complete First Report of Injury Form.
6. Have employee sign State Information Signature Page.
7. Have employee read and sign Payroll Checklist page.(effective 6/22/06)
8. Complete Accident and Injury Report Form.
9. Submit all signed forms mentioned above to Human Resources.

WORKERS COMPENSATION Informational Overview

WORKERS COMPENSATION

- Employee Injured
- Employee reports injury to supervisor.
- Supervisor
 1. Sends employee to Business Health for medical evaluation.
 2. Notifies Human Resources Department.
 3. Completes First Report of Injury Form.
- Human Resources submits First Report of Injury to Workers Compensation
 - Business Health notifies Human Resources verifying employee office visit and medical recommendations.
 1. Initial notification is by phone.
 2. Physician's Return to Work Report is then faxed.
- Upon release from Business Health employee reports to Human Resources.
 1. **By phone if physician advises employee not to return to work.**

Human Resources will notify supervisor:

 - FMLA notification is mailed to employee at this time.
 2. **In person if advised by physician they may return to full duty.**
 - Human Resources will notify supervisor that employee may return to full duty per physician's written report.
 3. **In person if advised by physician they may return to work with medical restrictions.**
 - Human Resources will notify supervisor that employee has been released to work with restrictions.

A Transitional Duty Plan is developed

IA-1 WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General	Employer (Name & Address incl. zip) City of Erlanger 505 Commonwealth Ave. Erlanger, KY. 41018				Carrier/Administrator Claim Number			Report Purpose Code				
					Jurisdiction		Jurisdiction Claim Number					
					Insured Report Number							
	Sic Code 9131				Employer FEIN 61-6001819		Employer's Location Address (if different)			Location No.		
									Phone No. 859-727-2525			
Carrier/Claims Admin	Carrier (Name, Address & Phone Number)				Policy Period			Claims Admin (Name, Address & Phone Number) Collins and Co. 225 E. Main St. Suite 7 Georgetown, KY. 40324				
					To							
					<input type="checkbox"/> Check if self insured							
	Carrier FEIN		Policy Number or Self-Insured Number				Administrator FEIN					
Agent Name & Code Number Kentucky League of Cities												
Employee/Wage	Legal Name (Last, First, Middle)			Date of Birth		Social Security Number			Date Hired		State of Hire	
	Address (Incl. Zip)			Sex		Marital Status			Occupation/Job Title			
				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		<input type="checkbox"/> Unmarried/Single/Div. <input type="checkbox"/> Married <input type="checkbox"/> Separated			Employment Status			
	Phone			No. of Dependents		Unknown			NCCI Class Code			
	Wage Rate \$		<input type="checkbox"/> Day <input type="checkbox"/> Week	<input type="checkbox"/> Month <input type="checkbox"/> Other	# Days Worked/WK			Full Pay for Date of Injury?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
				# Hrs Worked per Day			Did Salary Continue?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Occurrence	Time Employee Began Work	<input type="checkbox"/> AM <input type="checkbox"/> PM	Date of Injury or Illness	Time Occurred	<input type="checkbox"/> AM <input type="checkbox"/> PM	Last Work Date		Date Employer Notified		Date Disability Began		
	Employer Contact Name/Phone Number Vickie Wyatt 859-727-7957				Type of Illness/Injury			Part of Body Affected				
	Did Injury/Illness Exposure Occur on Employer's Premises?			Yes <input type="checkbox"/> No <input type="checkbox"/>	Type of Illness/Injury Code			Part of Body Affected Code				
	Department or location where accident or illness exposure occurred					All Equipment, Materials, or Chemicals Employee was using when accident or illness exposure occurred.						
	Specific Activity the Employee was engaged in when the accident or illness exposure occurred.					Work Process the Employee Was Engaged in when accident or illness exposure occurred.						
	How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.									Cause of Injury Code		
	Date Returned to Work		If Fatal, Date of Death			Were Safeguards or Safety Equipment Provided?			<input type="checkbox"/> Yes <input type="checkbox"/> No			
						Were they used?			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Treatment	Physician/Health Care Provider (Name & Address)			Hospital (Name & Address)			Initial Treatment					
							0 <input type="checkbox"/>	No Medical Treatment				
Other	Witness to Accident (Name & Phone Number)						1 <input type="checkbox"/>	Minor: By Employer				
							2 <input type="checkbox"/>	Minor Clinic/Hosp				
							3 <input type="checkbox"/>	Emergency Care				
							4 <input type="checkbox"/>	Hospitalized > 24 hr.				
							5 <input type="checkbox"/>	Future Major Medical/Lost Time Anticipated				
Date Administrator Notified		Date Prepared	Preparer's Name & Title			Preparer's Phone Number						

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		IMPORTANT STATE INFORMATION/SIGNATURE

Applicable in Kentucky and New York

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. In New York, such person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

EMPLOYEE SIGNATURE:

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Workers Compensation Disability PAYROLL CHECKLIST

Employee must sign and submit to their supervisor to be turned in to Human Resources along with their First Report of Injury.

EMPLOYEE NAME: _____

DATE:

DEPARTMENT: _____

DEPARTMENT HEAD: _____

I have read and understand the following with regard to my Workers Compensation claim.

- Workers Compensation rules mandate that they not pay any portion of a claimant's salary until the claimant is restricted from work for at least 14 days. Workers Compensation will begin paying 2/3 of salary beginning on day 15.
- The City of Erlanger will pay 2/3 of my salary **from day one**, plus an additional 1/3 at the rate of one week for every year of service.
- Should I be off work long enough to receive salary benefits from Workers Compensation, I am required to reimburse the City of Erlanger for their advance of the 2/3rd's payment.

NOTE:

Workers Compensation Payments do not apply toward CERS Service Credit. You must have PTO DISABILITY PAYMENTS (1/3 pay which the City pays at a rate of one week for every year of service), PTO or VACATION HOURS EACH MONTH, or you will have to buy back that time for calculating retirement. Please see either Missy Andress or Vickie Knochelman-Wyatt for special payroll accommodations.

Human Resources will review check summary to ensure enough hours are available to satisfy CERS requirements

Signature

Date

ACCIDENT / INJURY REPORT FORM

DEPARTMENT: _____ DATE & TIME
REPORTED _____

SUPERVISOR _____
Date and Time Accident was Reported _____

LOCATION OF ACCIDENT: _____

NAME & TITLE OF INJURED PERSON: _____

NAME & TITLE OF ALL WITNESSES: _____

DESCRIPTION OF INJURY

IF MEDICAL ATTENTION WAS RECEIVED, WHAT TYPE? _____

DRUG / ALCOHOL TEST ADMINISTERED? YES _____ NO _____

CAUSE OF INJURY: _____

TYPE OF VEHICLE / EQUIPMENT USED: _____

INJURED PERSON'S DESCRIPTION & CIRCUMSTANCES LEADING TO
ACCIDENT: _____

SUPERVISOR RECOMMENDATION FOR PREVENTING THIS ACCIDENT IN THE
FUTURE: _____

EMPLOYEE SIGNATURE: _____

SUPERVISOR'S SIGNATURE: _____

DATE RECEIVED: _____ RECEIVED BY: _____

REVIEWED BY SAFETY COORDINATOR: YES _____ NO _____

REVIEWED BY SAFETY COMMITTEE: YES _____ NO _____

FOLLOW UP NEEDED: YES _____ NO _____

PROPERTY DAMAGE/INCIDENT REPORT FORM

DATE OF INCIDENT: _____ DATE OF REPORT: _____

TIME OF INCIDENT: _____ A.M. _____ P.M.

LOCATION OF INCIDENT:

PROPERTY DAMAGED:

DAMAGE ESTIMATE IF KNOWN: \$ _____

CAUSE OF LOSS DUE TO: _____

POLICE NOTIFIED? YES _____ NO _____

IF YES, POLICE REPORT # _____

DRUG / ALCOHOL TEST ADMINISTERED? YES _____ NO _____

WITNESSES:

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

NAME: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

DATE RECEIVED: _____ RECEIVED BY: _____

FOLLOW UP NEEDED? YES _____ NO _____

MUST BE FILLED OUT WITHIN 24 HOURS OF INJURY/INCIDENT

**WORKERS COMPENSATION
MEDICAL WAIVER AND CONSENT**

I, _____, having filed a claim for workers' compensation benefits, do hereby waive any physician-patient, psychiatrist-patient, or chiropractor-patient privilege I may have and hereby authorize any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider to furnish to Commonwealth of Kentucky and/or Collins and Company any information or written material reasonably related to my work-related injury or my past relevant medical history.

The authorization includes, but is not restricted to, a right to review and obtain copies of all records, x-rays, x-ray reports, medical charts, prescriptions, diagnoses, opinions and courses of treatment.

This authorization shall remain valid for 180 days following its execution. A photocopy of the authorization may be accepted in lieu of the original.

Signed at: _____, Kentucky, this _____ day
Of _____, 20_____

Patient: _____

Social Security No. _____

Witness: _____

Pursuant to KRS 342.020(4) any physician, psychiatrist, chiropractor, podiatrist, hospital or health care provider shall, within a reasonable time, provide the requesting party with any information or written material reasonably related to the injury for which the employee claims compensation.

WORKERS COMPENSATION
PRESCRIPTIONS



MEDICAL INSURANCE should not be used for Medications prescribed due to a work related injury.

**During work hours prescription cost can be covered
Through Bridgeway Medical
By calling Angela Hopper
@
1-866-545-7800**

**After hours prescriptions must be self paid
and receipt turned in for reimbursement**

**If Medical Insurance is used in error, please advise Human Resources
and we will submit a reimbursement request**

Thanks

Supervisor Instructions

Family Medical Leave

1. Complete a Personnel Action Form ([link](#)) for any employee absent over three days for any of the following reasons.

- For the birth and care of the newborn child of an employee;
- For placement with the employee of a child for adoption or foster care;
- To care for an immediate family member (spouse, child, or parent) with a serious health condition;
- To take medical leave when the employee is unable to work because of a serious health condition

Note: Employee may be using vacation or PTO time so they receive a paycheck. FMLA runs concurrently.

2. Have employee complete a Request for Leave of Absence Form

3. Submit signed copies of the above mentioned forms to Human Resources.

F.M.L.A.

Informational Overview

The [Family and Medical Leave Act \(FMLA\)](#) provides certain employees with up to 12 weeks of **unpaid, job-protected leave** per year. It also requires that their group health benefits be maintained during the leave.

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

Employers must provide an eligible employee with up to 12 weeks of unpaid leave each year for any of the following reasons:

- For the birth and care of the newborn child of an employee;
- For placement with the employee of a child for adoption or foster care;
 - To care for an immediate family member (spouse, child, or parent) with a serious health condition;
- To take medical leave when the employee is unable to work because of a serious health condition.

Employees are eligible for leave if:

- They have worked for their employer at least 12 months
- They have a minimum at least 1,250 hours over the past 12 months
 - Hours of service are determined according to FLSA principles for determining compensable hours or work.
- They work at a location that employs 50 or more employees within 75 miles.

Whether an employee has worked the minimum 1,250 hours is determined by counting the actual number of hours the employee has worked in the previous 12-month period. Therefore, paid vacations, holidays, and sick leave are not counted. In addition, eligibility is determined as of the date the leave will actually begin, not when the employee requests the leave.

PROCEDURES

Department Head

4. Complete a Personnel Action Form ([link](#)) for any employee absent over three days for any of the following reasons.
 - For the birth and care of the newborn child of an employee;
 - For placement with the employee of a child for adoption or foster care;
 - To care for an immediate family member (spouse, child, or parent) with a serious health condition;
 - To take medical leave when the employee is unable to work because of a serious health condition

Note: Employee may be using vacation or PTO time so they receive a paycheck. FMLA runs concurrently.

5. Have employee complete a Request for Leave of Absence Form and return to Human Resources.

IMPORTANT CONSIDERATIONS FOR F.M.L.A.

- F.M.L.A runs concurrently with any type of qualifying employee absence.
- City must make qualifying determination and notify employee they are being placed on F.M.L.A.
- The City of Erlanger mandates the following with regard to F.M.L.A.
 - Tracking of F.M.L.A. is computed on a rolling 12-month method.
 - Married parents employed within the same department are limited to a total of 12 weeks combined leave in accordance with stipulations as outlined in D.O.L. CFR 825.202
- Employee must make payment arrangements for their portion of the premium on STD / LTD / LIFE Insurance if applicable.
- Employee must use accrued P.T.O. and vacation leave at the beginning of their F.M.L.A. leave. The exception to this is in the case of Workers Compensation.

