West Virginia

BRICKSTREET INJURY KIT

POLICY # WCB1025373

COMPANY NAME Taylor County Board of Education

CONTACT PERSON AND NUMBER Rhonda Clarkson 304-265-2497 x 130
Dara Britton 304-265-2497 x 115

JURISDICTION

Brickstreet® INSURANCE

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Taylor County Board of Education
Workers Compensation Insurance Information

To expedite your claim, please give this form to the receptionist at the medical facility in which you receive your initial treatment.

Job site injuries for employees of Taylor County Schools will be covered by BrickStreet Mutual Insurance as of July 1, 2017.

Insurance Carrier:	**BrickStreet Mutual Insurance**
Address:	**P. O. Box 3151** **Charleston, WV 25332-3151**
Telephone:	866.452.7425

If you have any questions, please feel free to contact me at 304-265-2497 X 30.

Sincerely,

Rhonda Clarkson
Professional Accountant – Taylor County Schools

Taylor County Board of Education
ACCIDENT REPORTING PROCEDURES

A. An *Employee* who is injured must immediately report the injury or incident to a supervisor or an appropriate person in management.

B. The *Supervisor or designee* must give the injured employee an "Accident Package". The package includes, but is not limited, to the following:

1. Employee's Accident Investigation form
2. Supervisor's Accident Investigation form
3. Witness Interview and Statement form
4. Attending Physician's Report form

C. The injured *Employee* must fill out and return to the supervisor, an "Employee's Incident Report", within 24 hours of the injury or illness. The "Employee's Incident Report" is part of the "Accident Package".

D. The Witness and Interview Statement form should be completed by anyone who observes the incident.

E. The *Supervisor or designee* must fill out a "Supervisor's Incident Report". The completed "Employee's Incident Report" and the "Supervisor's Incident Report" should be immediately *Scanned and e-mailed or faxed to the Taylor County School's Workers Compensation Coordinator. The e-mail is rclarkson@k12.wv.us and the fax number is (304) 265-2508.*

F. Whenever possible, if medical attention is needed, the injured employee's *Supervisor or designee* should go with the employee to the doctor or other medical provider.

G. The *Employee* should provide the treating physician with the "Attending Physician's Report".

H. The treating *Physician* should complete the "Attending Physician's Report", which will outline all restrictions.

I. The *Employee* must give the completed "Attending Physician's Report" to their supervisor or designee. **If** able, employees are expected to return to the worksite the very *SAME* day to report the physician's findings and to discuss modified or alternative work. **If** medical treatment occurs in the evening or at night, then the employee should report the physician's findings on the next work day. This will enable all parties to be kept abreast of the employee's condition.

J. The *Supervisor must scan and e-mail or fax a copy of the "Attending Physician's Report" to the Taylor County School's Workers Compensation Coordinator (rclarkson@k12.wv.us* or *(304) 265-2508),* and also keep a copy for themselves.

K. If the employee is restricted from work, the *Supervisor* should communicate regularly with the employee and treating doctor. The *Supervisor* should talk with the employee on the day of the injury and once a week until the employee returns to work.

L. When the treating physician releases the injured employee to "Modified or Alternative work", the *Supervisor* should attempt to develop an alternative assignment. Every assignment must meet the physician's restrictions.

M. The *Supervisor* must follow up with the employee on a regular basis while the injured employee performs modified or alternative work.

O MINOR
O FIRST AID
O ILLNESS
O LOST WORKDAY
O MEDICAL

TAYLOR COUNTY BOARD OF EDUCATION
REPORT OF INJURY

EMPLOYEE'S DESCRIPTION OF EVENT

NAME._____ SS NUMBER._____

HOME ADDRESS_____

(STREET) (CITY) (STATE) (ZIP)

MALE FEMALE DATE OF BIRTH_____HOME TELEPHONE_____

WORK LOCATION _____ ACCIDENT LOCATION_____

DATE OF ACCIDENT_____TIME_____O am O pm

DATE STOPPED WORK DUE TO lNJURY_____TIME STOPPED WORK DUE TO lNJURY_____O am O pm

REGULAR WORK SCHEDULE: Start _____O am O pm Stop._____O am O pm OCCUPATION._____

TYPE OF INJURY(S): (Check all that apply)

O Cut (Laceration)	O Amputation	O Burn (Mild)	O Abrasion
O Fracture	O Insect Bite	O Puncture	O Electrical Shock
O Dislocation	O Rupture	O Strain/Sprain	
O Contusion	O Burn (Moderate to Severe)	O Rash	O Other_____

INJURED PART OF BODY: (Check all injured parts)

RT	LT		RT	LT		RT	LT			
O	O	Eye	O	O	Wrist	O	O	Calf	O Head	O Abdomen
O	O	Collarbone	O	O	Hand	O	O	Knee	O Mouth	O Groin
O	O	Shoulder	O	O	Thumb	O	O	Ankle	O Teeth	O Finger
O	O	Arm	O	O	Hip	O	O	Foot	O Neck	O Toe
O	O	Elbow	O	O	Leg	O	O	Instep	O Nose	O Chest
O	O	Forearm	O	O	Thigh	O	O	Ribs	O Back	O Other_____

Identify which finger or toe injured_____

Describe the accident, explaining what you were doing, how you were doing it, where you were, etc. (Including equipment, material and/or chemicals being used.)

_____

_____

_____

_____

NATURE OF EVENT:

O Fall (Same Level)	O Caught In	O Struck By	O Exposure
O Fall (Up Different Lvl)	O Caught On	O Struck Against	O Exertion
O Fall (Dn Different Lvl)	O Caught Between	O Electrical Contact	O HandTool
O Slip/trip	O Stepped in Hole	O Chemical Agent	O Hot Surface
O Cutting Edge	O Falling Object	O Inhalation	O Other_____

WITNESSES: **Name**	Address	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you anticipate seeking medical attention? __Yes __No

SIGNATURE OF EMPLOYEE_____ Date: _____

ACCIDENT MUST BE REPORTED IMMEDIATELY TO YOUR IMMEDIATE SUPERVISOR. INJURY REPORT, INVESTIGATION REPORT AND WITNESS REPORTS MUST BE SENT TO BUSINESS OFFICE WITHIN 24 HOURS OF ACCIDENT.

Taylor County Board of Education
Occupational Injury Investigation Report
To be completed By Immediate Supervisor

Mark N.A. (not applicable) items that do not apply to the incident. Write "none", "unknown", or "don't know" for applicable items for which there is not answer

This report must be completed and attached to the Injured Employee Report and Witness Interveiw Reports if applicable and sent to the Business Office within 24 hours of accident

Name of Injured Employee _____ Work Locaiton _____

Age _____ Sex M F SSN _____ Occupation _____

Date of Accident | Time of Accident am/pm | Date Injury Reported | Date Lost Time Began

Please answer the following questions

1. Describe injury (type, body part, etc _____

2. Exact Location at which accident occurred _____

3. What happened? Describe the accident explaining what the employee was doing, how employee was doing it, what initiated the accident, type of accident (fall, trip, cut, exertion, etc.) and any relevant background information pertaining to this accident.

4. Did the Injured or other person do or fail to do anything that contributed directly to the accident? Be specific, (Ex:: "Used ladder too short for job", "stood on folding chair", "failed to secure ladder".) Do not say "careless", "poor judgment", etc.

5. Did any defective or otherwise unsafe condition(s) of tools, equipment, machinery, structures, or work area contribute directly to the accident? If so, describe in detail.

6. Were pictures taken of the scene of the accident? Yes No

7. Were there any witnesses? Yes No

8. If there were witnesses, did they complete a Witness Interview Report? Yes No

Additional Comments _____

Date of Report _____

If employee seeks medical attention, have employee contact business office so proper information can be sent to Workers' Compensation. Employee cannot return to work until Business Office receives a release from the employee's physician.

Signature of Immediate Supervisor (if applicable)

Signature of Immediate Supervisor (if applicable)

Taylor County Board of Education
Witness Interview and Statement

NOTE: Complete a witness report for each witness interviewed. Attach additional reports, if any to the Investigative Report

Please answer the following questions

1. Date and Time of Injury _____

2. Exact Location at which accident occurred _____

3. Did the individual appear to be injured - if so, how: _____

4. Describe, in your own words, how the injury occurred (what was the individual doing). _____

5. Name(s) of other witnesses: _____

6. Describe, in your own words, how you feel the injury could have been prevented or could be prevented in the future: _____

Witness Signature _____ Date: _____

Principal/Supervisor _____ Date: _____

ATTACHED COMPLETED REPORT TO EMPLOYEE ACCIDENT REPORT AND SEND TO BUSINESS OFFICE WITHIN 24 HOURS

ATTENDING PHYSICIAN'S REPORT

Patient's Name: _____
Employer: Taylor County Board of Education

Dear Doctor:

Please provide the following information related to this injury/illness. This will assist us in returning our employees to work.

1. ____ Employee may return to normal duties at once.
2. ____ Employee may return to work with the following restrictions.

Hours/Day: □ No Restrictions □ 8 hours □ 6 hours □ 4 hours □ other _____

Days/Weeks: □ No Restrictions □ 5 days □ 4 days □ 3 days □ other _____

Lifting: □ No Restrictions □ 40 lbs □ 30 lbs □ 20 lbs □ 10 lbs □ other

Movement: □ No Restrictions □ Limited Stooping □ Limited Bending
□ Limited Overhead Reaching □ Other _____

Other (please specify): _____

Length of restrictions: Resume regular duties after _____ days, ***or***
Employee will be re-evaluated on (date) _____

3. The employee is totally incapacitated at this time. Employee will be re-evaluated on: (date) _____.

4. **Notice to physician and employee: This report must be returned to Employee's Employer within 24 hours of this office visit.**

   I saw the patient on: (date) _____ and have made the following diagnosis:

   DX: _____

   _____

5. Comments: _____

   _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (Print) Name of Hospital/Clinic

_____
Address of Hospital/Clinic

_____
Phone of Hospital/Clinic

First Fill Information
BrickStreet

Dear Injured Worker,

Optum® has been selected by **BrickStreet** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Optum has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at **cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: **1-800-419-7191.**

Estimado Trabajador(a) Lesionado(a),

Optum ha sido seleccionado por **BrickStreet** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Optum cuenta con una extensa red de farmacias al por menor. De la red de farmacias Optum incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en **cypresscare.com** y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: **1-800-419-7191.**

First Fill Form: Complete and take to your pharmacy

Bin #: 010876 **Group Number: BRICKSTREET**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:	Taylor County Board of Ed	
Date of Injury:		

Pharmacy Help Desk: **1-800-419-7191.**

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 14-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at **1-800-419-7191.**

Issuance of this letter does not constitute acceptance of your claim.

Accident Packets
Workers Compensation FAQ

- ***What if I am hurt, but I don't feel "hurt enough" to go to the doctor?***

  If you are hurt, you should complete an accident form, and when in doubt, you should seek medical attention as soon as possible. Delayed reporting of injuries could jeopardize your eligibility for benefits and certainly delay payment of claims to injured employees.

- ***Will I receive excused leave for days I miss work related to my injury?***

  No. Employees are required to use sick days during their time off work due to an accident.

- ***Will workers comp pay me or give me credit for lost sick days?***

  Workers comp Total Temporary Disability (TTD) benefits, or payment of lost wages, becomes available if an employee misses at least three consecutive days following an accident. Benefits become available on the fourth consecutive day missed. If an employee misses eight consecutive days, missed days one through three become benefit-eligible. TTD benefits pay the employee 2/3 of their normal daily salary or the employee may continue to use sick days and use the benefits to "buy back" used sick days. All employees eligible for TTD benefits must sign an election form during the claim process.

- ***When I visit the doctor, should I just tell them to "put it on the Board's tab"?***

  Unfortunately, no. This does not mean medical expenses related to a work-related injury will not eventually be paid by the Board's workers compensation policy, but employees should use their personal insurance information when going to the doctor. Completed accident packets will be submitted to the Board's insurance carrier and eligibility will be determined by the insurance company. The Board does not write checks to employees for medical expenses or make payments to healthcare providers on their behalf.

- ***How do I ensure that workers comp pays my medical bills?***

  Follow the instructions in the accident packet and submit forms to each specified party as soon as possible to expedite the claim process. You can follow-up with the insurance company using the contact information provided on page one of the accident packet.