caddo
parish public schools

WORKERS' COMPENSATION CLAIM PROTOCOLS

Risk Management
Caddo Parish School Board
1961 Midway Avenue, Shreveport, LA 71108
Telephone (318) 603-6321
Fax (318) 603-6320

Jeff Chitwood – Risk Manager
Telephone: (318) 603-6314
Cell (318) 254-9214
Email: jbchitwood@caddoschools.org

Amended June 2022

CONTENTS

Caddo Parish School Board is required by Louisiana Workers Compensation statutes to provide medical and wage loss benefits to eligible employees who experience a compensable work-related injury or disease. This protocol provides information to employees and supervisors about the requirements and responsibilities relating to the reporting of work-related injuries.

I. SUMMARY OF RESPONSIBILITIES IMMEDIATELY FOLLOWING AN ON THE JOB ACCIDENT AND/OR INJURY

Employee Responsibilities

- Immediately notify your principal, manager or supervisor. The principal, manager, supervisor or director will assess the situation, assist with arranging proper medical care and begin the injury reporting process.
- No later than 1 business day, the employee must complete the Employee Statement of Injury or Accident Form (RM-4).
- Promptly cooperate with your principal/manager/supervisor/director, risk management and the third party claims administrator (FARA/York) in the completion of all relevant documents and the investigation of the claim.
- Maintain contact with your direct supervisor. Provide your direct supervisor with all work status reports after each physician visit.

Principal/Manager/ Supervisor/Director Responsibilities

- Immediately assess the incident and assist the employee in seeking appropriate medical care or necessary treatment for any work-related injury. If an injury is a potential life-threatening emergency, call 911. Consult with nursing staff, if available at your location.
- Upon receiving notice of an accident or occupational injury/disease, provide the employee with an Employee Statement of Injury or Accident Form (RM-4) to complete. The Employee Statement of Injury or Accident Form (RM-4) is an internal form in which the employee can provide their version of the accident, incident or occupational disease.

- The employer is required by state law to complete a LWC-WC IA-1 Workers Compensation – First Report of Injury or Illness. This form is to be completed by the employer. **DO NOT give this form to the employee to complete.** This form must be completed by the principal, supervisor, manager or director. This is a state mandated form.

- **Both forms should be promptly submitted to Risk Management by fax, mail or e-mail in order to comply with state reporting requirements.** A copy of both forms should be kept on file at the department level and a copy provided to the employee. **All required forms should be submitted to Risk Management within 24 hours.**

- **Within 3 business days, fax, mail or e-mail all written witness statements to Risk Management.**

- Maintain regular contact with the injured employee.

II. INVESTIGATION

The initial accident investigation is required to determine the basic causes of the accident by asking the questions who, what, where, when, and how.

It's crucial that investigations begin rapidly while memories are fresh. It is imperative to obtain the required documentation from the employee and witnesses regarding their knowledge of all accidents.

Your accident investigation is a means of finding factual data of an accident with the intention of facilitating, changing or improving the work environment for your employees.

The third party claims administrator (FARA/York) will conduct an investigation to determine claim compensability.

General guidelines for investigating accidents:

- Inspect and record any physical characteristics or conditions of the accident site immediately after the alleged accident;
- Have the injured employee provide details regarding the accident, if possible;
- Ask simple open-ended questions, one question at a time, and attempt to have events related chronologically to ensure thorough coverage;
- Ask when, where, who, how, and what was said or done;

- Have witnesses provide a written statement;
- Avoid commenting on the information gathered except to confirm your understanding or to clarify;
- Avoid opinions, judgments or conclusions, and be as objective as possible;
- Preserve any physical evidence, such as potentially defective equipment, and notify risk management.
- If there is video of the accident, provide the camera number/date/time when reporting the claim. Promptly preserve all video related to the accident. If you have questions regarding the preservation of videos, contact the Security Department or Risk Management for further information.

III. INITIAL MEDICAL CARE FOR WORK RELATED INJURIES

For injuries requiring immediate emergency assistance, dial 911.

All serious injuries requiring transport by ambulance, emergency surgery and/or death must be reported to risk management by telephone at (318) 603-6314 or (318) 603-6321. Written documentation will still need to be submitted as outlined above.

When a work related injury requires medical attention, Caddo Parish School Board encourages the use of Work Kare. This provider is familiar with the workers' compensation process. Appointments are not required for initial treatment but can be scheduled.

The employee will need to take a Work Kare Authorization to Treatment form with them to the initial appointment. In the alternative, a copy of the Workers Compensation - First Report of Injury (LWC-WC-1A) form can be provided to Work Kare as approval for initial treatment.

After normal business hours, employees may be seen at any of the Willis Knighton urgent care centers, Quick Care, open daily from 7:00 am to 7:00 pm or at any Willis Knighton emergency room.

In the event the employee is seen at the emergency room or at Quick Care, follow-up care will need to be coordinated at a Work Kare facility.

OPTUM administers the prescription drug program for the work related injuries. The prescription drug program will eliminate co-pays and out-of pocket expenses for medications prescribed for an accepted workers compensation claim. Work Kare will provide information regarding pharmacy benefits to the employee at the time of their initial medical treatment.

Under Louisiana law, an injured employee has the right to select his/her own treating physician. If the employee chooses to see their physician of choice, they will also need to be seen at Work Kare so post-accident protocols can be followed (post-accident drug screen, evaluation by the employer's choice of physician, and pharmacy card).

IV. CLAIM REPORTING

Any employee who sustains a work-related injury or illness is to report the incident immediately to his/her principal, manager or supervisor.

The **employee** is to complete and sign the **Employee Statement of Injury or Accident Form (RM-4)** and return to his/her principal, manager or supervisor. It is the responsibility of the principal, manager or supervisor to review the Employee Statement of Injury or Accident Form (RM-4) completed by the employee to confirm it is complete.

The **principal/manager/supervisor/director** is required to complete the **Workers Compensation - First Report of Injury (LWC WC 1A)**. This is a mandatory form required by the LA Office of Workers' Compensation.

The completed forms are to be forwarded to Risk Management within 24 hours. A copy should be retained by the department or school for their records. The Risk Management fax number is (318) 603-6320.

It is imperative that FARA/York, Risk Management, Payroll and Personnel are contacted promptly when an employee becomes disabled from work.

The principal, manager or supervisor cannot deny the injured worker the right to file an accident/illness report. If an employee alleges an on the job injury that is questionable, the forms outlined above will need to be submitted. If the accident is questionable or it does not appear the injury is work related, the principal/manager/supervisor/director must notify risk management of this when the claim forms are submitted. This notice alerts the claim staff that further investigation is required. It is the responsibility of the claim staff and risk management to determine compensability.

Within 3 business days, fax, mail or e-mail all written witness statements to Risk Management.

V. RETURNING THE EMPLOYEE TO WORK

The employee will be provided with a work status report at each physician visit. The work status report will indicate if the employee can return to work and whether job modifications are required to accommodate physical restrictions. The employee will need to provide a copy of this report to the principal, manager or supervisor.

Employees without restrictions can return to their usual work duties.

If the medical provider imposes work restrictions, the principal, manager, supervisor or director and the claims administrator (FARA/York) will review the job modifications that are required to comply with the restrictions. Every effort will be made to accommodate the employee's restrictions.

VI. DOCUMENTATION AFTER INITIAL CLAIM REPORTING

The Caddo Parish School Board is self-insured for workers' compensation claims. FARA/York administers the workers compensation claims. Documentation related to an on the job accident or illness that is received after the claim is initially reported should be forwarded directly to FARA/York.

The claims administrator is responsible for investigating the claims and determining claim compensability. They also work with medical providers to ensure that employees receive high-quality, timely medical care and paying all approved medical bills and employee indemnity benefits that are due.

If the injured worker returns to work or becomes disabled after a claim is reported, it is imperative that FARA/York, Risk Management, Payroll and Personnel are contacted immediately.

Questions regarding specific workers compensation claims should be directed to FARA/York.

VII. Contact Information

Risk Management
Caddo Parish School Board
1961 Midway Avenue
Shreveport, LA 71108
Telephone (318) 603-6321
Fax (318) 603-6320

Jeff Chitwood – Risk Manager
Telephone (318) 603-6314
Cell (318) 254-9214
Email: jbchitwood@caddoschools.org

Tanny Days – Risk Management Secretary
Telephone (318) 603-6321
Fax (318) 603-6320
Email: tdays@caddoschools.org

CONTACT INFORMAITON FOR CLAIM ADMINISTRATOR/ADJUSTORS

SEDGWICK
(318) 797-1055
www.sedgwick.com

Andrea Seaton – Adjuster
(318) 797-1055 Ext. 11501 or andrea.seaton@sedgwick.com

Karen Hooks – WC Supervisor
(318) 797-1055 Ext. 11500 or karen.hooks@sedgwick.com

WORKERS' COMPENSATION FORMS

- **RM-4 Employee Statement of Injury or Accident**

  To be completed by the employee.

- **LWC-WC 1A1 - Workers Compensation – First Report of Injury or Illness** with instructions.

  To be completed by the principal, manager, or supervisor.

- **Work Kare Authorization to Treat** (with list of locations)

  Provide to employee to take with them for initial medical care.

(The Employee Statement of Injury or Accident Form (RM-4) and LWC-WC 1A1 – Workers Compensation – First Report of Injury or Illness Form are also found online at the Caddo Website under Forms.)

EMPLOYEE STATEMENT OF INJURY OR ACCIDENT

CADDO PARISH SCHOOL BOARD
Risk Management

NOTE: THIS FORM MUST BE COMPLETED BY THE EMPLOYEE ONLY.

EMPLOYEE INFORMATION

EMPLOYEE NAME *(Last, First, Middle)*			TELEPHONE NUMBER	
SCHOOL/DEPARTMENT			DATE OF HIRE	
JOB TITLE	☐ FULL-TIME ☐ PART-TIME	NAME OF SUPERVISOR/MANAGER		
EMPLOYEE ADDRESS (Street)				
(City)			(State)	(Zip Code)
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MARITAL STATUS	RACE	☐ MALE ☐ FEMALE

ACCIDENT/INJURY INFORMATION

DATE OF INJURY OR ILLNESS	TIME OF INJURY OR ILLNESS	☐ AM ☐ PM	DID INJURY/ACCIDENT OCCUR OCCUR AT A CPSB PROPERTY? ☐ YES ☐ NO
IF SO, NAME OF SCHOOL/DEPARTMENT	LOCATION AT SCHOOL *(Be specific)*		
DATE EMPLOYER NOTIFIED OF INJURY/ILLNESS	TIME EMPLOYER NOTIFIED OF INJURY/ILLNESS	☐ AM ☐ PM	
NAME OF PERSON INJURY/ILLNESS REPORTED TO	WAS THE INJURY/ILLNESS REPORTED VERBALLY OR IN WRITING?		
DESCRIBE THE SPECIFIC ACTIVITY YOU WERE ENGAGED IN AT THE TIME OF THE ACCIDENT OR ILLNESS			
LIST ALL EQUIPMENT, MATERIALS AND CHEMICALS THAT WERE BEING USED AT THE TIME OF THE ACCIDENT OR ILLNESS			
HOW DID THE ACCIDENT/INJURY OCCUR? *(Be specific)*			
NAME AND TELEPHONE NUMBER OF ALL WITNESSES			
DESCRIBE ALL BODY PART(S) THAT WERE INJURED	DESCRIBE TYPE OF INJURY TO EACH BODY PART LISTED		
DATE EMPLOYEE RETURNED TO WORK	IF YOU MISSED TIME FROM WORK, PROVIDE DATES		
NAME AND ADDRESS OF ALL MEDICAL CARE PROVIDERS AND/OR FACILITIES WHERE YOU HAVE RECEIVED MEDICAL CARE			

I UNDERSTAND THAT IT IS UNLAWFUL TO MAKE A FALSE STATEMENT OR REPRESENTATION IN ORDER TO OBTAIN WORKERS' COMPENSATION BENEFITS. I UNDERSTAND THAT MY FAILURE TO ANSWER ANY OF THE ABOVE QUESTIONS TRUTHFULLY MAY RESULT IN MY FORFEITURE OF ANY AND ALL WORKERS' COMPENSATION BENEFITS UNDER LA. REV. STAT. ANN. § 23:1208.

_____ _____

Employee Signature Date

Principals/Supervisors/Managers shall submit to Risk Management with the mandated First Report of Injury or Illness within 24 hours of the accident or on notice of the injury/illness.

RM-4 7/15

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
Caddo Parish School Board 1961 Midway, Shreveport, LA 71108 PO Box 32000, Shreveport, LA 71130-2000	JURISDICTION LA	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
N/A	TO CHECK IF APPROPRIATE SELF INSURANCE ☑	York Risk Services Group 6425 Youree Dr., Suite 420, Shreveport, LA 71105 (318) 797-1055

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
N/A	N/A	

AGENT NAME & CODE NUMBER
N/A

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY WEEK	☐ MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	☐ YES ☐ YES	☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS 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 RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	☐ YES ☐ NO
	N/A	WERE THEY USED?	☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC/HOSP ☐ EMERGENCY CARE ☐ HOSPITALIZED > 24 HOURS ☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:
Enter all dates in MM/DD/YY format.

INDUSTRY CODE:
This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:
The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:
Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:
Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:
This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:
Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:
The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:
Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:
Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:
Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:
Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:
(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:
Enter the date following to most recent disability period on which the employee returned to work.

☐ **WK Work Kare-North**
2724 Greenwood Road
Shreveport, LA 71109
318-212-4750
Fax 318-212-4545

☐ **WK Work Kare-Bossier**
2300 Hospital Dr, Ste 360
Bossier City, LA 71111
318-212-7750
Fax 318-212-7757

Willis-Knighton Work Kare

☐ **Work Kare Drug Testing Center**
2738 Greenwood Road (next to North)
Shreveport, LA 71109
318-212-TEST
Fax 318-212-4539
A clinic for drug & alcohol testing!

☐ **WK Work Kare-South**
2520 Bert Kouns Ind Loop
Shreveport, LA 71118
318-212-5750
Fax 318-212-5755

☐ **WK Work Kare-Pierremont**
1666 E Bert Kouns, Ste 105
Shreveport, LA 71105
318-212-3750
Fax 318-212-3755

Authorization To Treat

Date: _____ Social Security No: _____

Employee: _____ Employer: _____

Contact Person: _____ Phone: _____

☐ Work Injury Treatment

Physical Examination:
☐ Pre-placement Medical Exam
☐ DOT or CDL Certification Exam
☐ Respirator Certification Exam
☐ Annual Exam

Medical Testing:
☐ Audiometric Testing
☐ Post Offer Employment Screening
☐ Performance Function Test
☐ PFT/Spirometry
☐ EKG
☐ Chest X-ray ☐ 1 view ☐ 2 view
☐ Lumbar Spine X-ray ☐ 3 view ☐ 5 view

Lab Testing
☐ Hepatitis B Titer
☐ Complete Blood Count (CBC)
☐ Blood Chemistry Level
☐ Lipid Profile (cholesterol %)
☐ Urinalysis
☐ Blood Lead Level
☐ TB Skin Test
☐ Heavy Metal Panel

Vaccination
☐ Hepatitis B Series ☐ Hepatitis A Vaccination
☐ Flu ☐ Tetanus ☐ Other _____

☐ Substance Abuse Testing

Reason:
☐ Pre-employment ☐ Post Accident ☐ Random
☐ Reasonable Suspicion ☐ EAP ☐ Return-to-Duty
☐ Follow-Up ☐ Observed

****PHOTO ID IS REQUIRED FOR TESTING****

Type of Test:
☐ SAP 5 Urine Drug Test ☐ SAP 10 Urine drug test
☐ SAP 10 with opiates ☐ Med Profile
☐ DOT Breath Alcohol ☐ Breath Alcohol
☐ DOT Collection ☐ Non-DOT Collection
☐ SAP 10 w/ urine alcohol ☐ Hair Testing
☐ Quick Screen: ☐ SAP 5 ☐ SAP 10
☐ Oral-Eze Fluid ☐ K-2 Synthetic Marijuana
☐ SAPFIRE ☐ SAP 10 W/Opi/Subutex
☐ DOT Drug Screen—Please select DOT Agency
☐ FMCSA ☐ FRA ☐ PHMSA
☐ FAA ☐ FTA ☐ USCG

Special Instructions: _____

_____

_____

WORK KARE LOCATIONS

Work Kare - North
2724 Greenwood Road
Shreveport, LA 71109
(318) 212-4750
Fax: (318) 212-8515
Hours: M-F 7:00 am - 5:00 pm

Work Kare - South
2520 Bert Kouns Industrial Loop, Suite 105
Shreveport, LA 71118
(318) 212-5750
Fax: (318) 212-5755
Hours: M-F 8:00 am - 4:30 pm

Work Kare - Drug Testing Center
2738 Greenwood Road
Shreveport, LA 71109
Phone: (318) 212-8378
Fax: (318) 212-4539
Hours: M-F 8:00 am - 4:30 pm

Work Kare - Pierremont
1666 E. Bert Kouns Industrial Loop, Suite 105
Shreveport, LA 71105
(318) 212-3750
Fax: (318) 212-3755
Hours: M-F 8:00 am - 4:30 pm

Work Kare - Bossier
2300 Hospital Drive, Suite 360
Bossier City, LA 71111
(318) 212-7750
Fax: (318) 212-7757
Hours: M-F 8:00 am - 4:30 pm

QUICK KARE LOCATIONS

Quick Care - Pierremont
1666 E. Bert Kouns Industrial Loop
Shreveport, LA 71105
(318) 212-3520
Hours: 7:00 am – 7:00 pm

Quick Care - South
2520 Bert Kouns Industrial Loop
Shreveport, LA 71118
(318) 212-5520
Hours: 7:00 am – 7:00 pm

Quick Care - Bossier
2300 Hospital Drive
Bossier City, LA 71111
(318) 212-7520
Hours: 7:00 am – 7:00 pm

WK EMERGENCY ROOM LOCATIONS

Willis-Knighton Medical Center
2600 Greenwood Road
Shreveport, LA 71103
(318) 212-4000

Willis-Knighton South
2510 Bert Kouns Industrial Loop
Shreveport, LA 71118
(318) 212-5000

WK Bossier Health Center
2400 Hospital Drive
Bossier City, LA 71111
(318) 212-7000

WK Pierremont Health Center
8001 Youree Drive
Shreveport, LA 71115
(318) 212-3000

LOUISIANA STATE WORKERS' COMPENSATION FORMS TO BE POSTED AT ALL LOCATIONS

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

1 the disease manifests itself.

2 the employee is disabled as a result of the disease.

3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

1 the date of death.

2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

Caddo Parish School Board - Self Insured

1961 Midway Avenue

Shreveport, LA 71106

Attention: Risk Management

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Jeff Chilwood

Risk Management

318-603-6314

318-603-6320 (fax)

Employer

Caddo Parish

School Board

1961 Midway Avenue

Shreveport, LA 71108

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

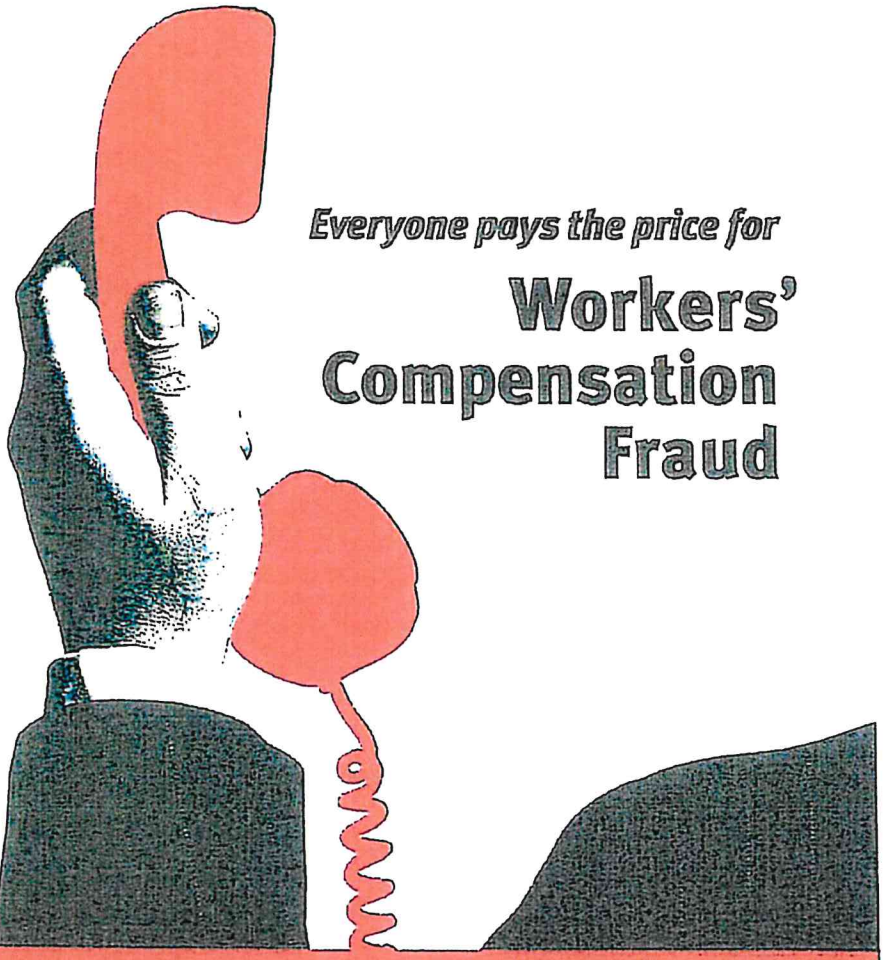
Revised May 2003

LOUISIANA WORKFORCE COMMISSION

www.laworks.net

An Equal Opportunity Employer Program. Auxiliary aids and services are available upon request to individuals with disabilities. 1-800-257-5154 (TDD)

Is someone you know **cheating** the system?



Everyone pays the price for

Workers' Compensation Fraud

Nationwide Toll-free Fraud Hotline

1.800.201.3362

(all information remains anonymous)

Louisiana Workforce Commission

www.LAWORKS.net

Office 225.342.7558
Fax 225.342.1880
Email WCFraud@ldol.state.la.us