Workers Compensation Procedures for Schools:

1. **Contact Chad Palmer at 864-206-2220 or 864-490-3488** as soon as reasonably possible after an accident occurs to report the injury if it requires medical treatment.
2. The employee should complete the full Employee Incident Report in their own writing. This document must be completed on site at the time of injury unless the injury requires emergency treatment. In those situations, have the employee complete it as soon as reasonably possible.
3. Using the information on the Employee Incident Report the building administrator or supervisor should complete the "Job Related Injury Form 1-A" in the packet and sign it.
4. If there are witnesses every witness named MUST complete the witness statement form.
5. Make sure the employee signs and dates the Medical Release form.
6. Provide the employee with the included "Notice to Provider" form and tell them to give it to the doctor. If the injury is serious enough to require immediate medical attention provide the same form to the responding paramedics.
7. Send the complete incident package to the district office as soon as possible. **If you have to send it without an administrator's signature that is fine. You can always submit the signed version later.**

Network Provider:
CMC - Center for Family Medicine – Peachview
Preferred Physician is Dr. Ruffing
722 Hyatt Street Suite C
Gaffney, SC 29341
864-489-2400

Questions? Concerns?

Contact Chad Palmer at 864-206-2220 or 864-490-3488

Policy GBGD Workers' Compensation

Issued 4/17

The board of trustees provides workers' compensation insurance coverage for all district employees. Volunteers who are not employees are exceptions to this policy.

The South Carolina Workers' Compensation Law is designed to provide medical and monetary benefits for an employee who sustains an accidental injury arising out of and in the course of his/her employment. The law provides medical care to bring about the earliest possible recovery from the injury, a percentage of wages and salary lost during the injured employee's disability, and, in case of death, compensation for the deceased employee's dependents.

Under the Workers' Compensation Law, it is the responsibility of the school district to provide medical treatment for employees injured on the job. School employees must use those providers specified by the employer. Designation of medical treatment providers will be made by the school district in consultation with and upon the recommendation of the workers' compensation insurance carrier. The refusal of an employee to accept any medical, hospital, surgical, or other treatment when provided by the employer will bar such employee from further compensation until such refusal ceases unless, in the opinion of the South Carolina Workers' Compensation Commission, the circumstances justified the refusal.

When an employee is absent from work as a result of accidental injury arising out of and in the course of his/her employment, available sick leave, annual leave, and workers' compensation benefits can be coordinated to the extent that such leave and benefits are available.

An injured employee may not return to work without a signed physician's return to work certificate. If an injured employee's treating physician indicates the employee may return to work but only with light or restricted duties, the district will determine whether suitable light duty is available. If an employee refuses a light duty assignment, the employee may forfeit his/her right to workers' compensation benefits. If light duty is unavailable, the employee may not return to work until the employee's physician releases him/her to full duty.

Every injured employee or his/her representative will immediately, on the occurrence of an accident or as soon thereafter as practicable, give or cause to be given to his/her principal or immediate supervisor and to the district office notice of the accident. Failure to provide notice within 90 days of the accident may deprive the injured employee of his/her rights to benefits.

Adopted 8/20/74; Revised 6/14/94, 4/18/11, 4/10/17

Legal references:

S.C. Code, 1976, as amended:

Section 42-1-10, *et seq.* - South Carolina Workers' Compensation Law.

South Carolina Workers' Compensation Commission Regulations:

R67-101, *et seq.* - South Carolina Workers' Compensation Commission.

Cherokee County School District

Employee must complete

Cherokee County School District
Workers' Compensation
INCIDENT REPORT

To be completed by injured party.
Please answer every question.

Your Name: _____
First Middle Last

Your School Name: _____

Your Address: _____
Street City State Zip

Telephone Number: _____ **Social Security:** _____ **Age:** _____

Date of Birth: _____ **Job Title:** _____ **Length of Employ:** _____

Date of Injury: _____ **Describe how you were injured:** _____

_____

_____

Did your injury occur from one specific incident? _____

Did your injury develop gradually over a period of time? _____
If yes, please indicate period of time:

From: _____ _____ **To:** _____ _____ **Describe how injury developed.** _____
Date Time Date Time

_____

_____

_____

Were you lifting or moving an object when you were injured? _____

Give the approximate weight of the object: _____

What position were you in at the time of your injury? (Example: Sitting, Standing, Squatting, Bending, etc.)

_____

Employee must complete

Workers' Compensation Incident Report

Page 2

When did you first realize you were injured? _____ _____.
Date Time

Who at work, did you first tell about your injury? _____

When did you tell them? _____ _____.
Date Time

Name of your supervisor: _____

If injury was not reported to your supervisor on the date you were injured, please state the reason it was not reported: _____

Name(s) of person(s) who witnessed your injury: _____

List parts of your body injured: _____

Additional Remarks: _____

_____

_____

I certify the answers given to these questions are correct and accurate to the best of my ability.

_____ _____
Employee Signature **Date**

Please scan and e-mail all completed forms to chad.palmer@cherokee1.org or fax to 864-902-3524

Employee must complete prior to doctor's visit

MEDICAL INFORMATION RELEASE AUTHORIZATION

TO WHOM IT MAY CONCERN:

IN RE: Claimant's name: _____
SSN: _____
Date of birth: _____

You are hereby authorized and directed to furnish to the South Carolina School Boards Insurance Trust, or to its representative, adjuster, attorney or other agent, any and all information in your possession, or under your control relating to my medical or dental care, including but not limited to the following:

(a) Hospital records, x-rays, x-ray readings and reports, laboratory records, pharmacy records, and reports, all tests of any type or character, and reports thereof, statement of charges, and any and all of my records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expenses;

(b) Medical, dental, psychological, psychiatric, pharmacy, or chiropractic records, including patient's record cards, nurses and doctor's daily notes, x-rays, x-ray readings and reports, laboratory records and reports thereof, statements of charges, and any and all of my records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.

You are further authorized and directed to furnish oral and written reports and information to the South Carolina School Boards Insurance Trust, its representative, adjuster, attorney or other agent, as requested by it on any of the foregoing matters, and to allow it to review any records relating to my workers' compensation claim or to confer with it concerning my workers' compensation claim.

Date:_____ _____
CLAIMANT

NOTE: A photocopy of this authorization shall have the same effect as the original.

Please scan and e-mail all completed forms to chad.palmer@cherokee1.org or fax to 864-902-3524

Employee must take to the doctor with them!

SCSBIT
THE SOUTH CAROLINA
SCHOOL BOARDS INSURANCE TRUST

Notice to Provider

(To be presented to doctor, hospital, or clinic by injured party when reporting for treatment)

_____ has reported that he/she was injured in our
(employee name)
employ on _____ .
(date of injury)

Please forward all reports and bills to

South Carolina School Boards Insurance Trust
Attn: Workers' Compensation
111 Research Drive • Columbia, SC 29203
1-800-326-3679

or

email to
Danny Deal
ddeal@scsba.org

Cherokee County School District — 864-206-2220
School Location / Employer — Phone

_____ — _____
Employer Signature (authorizing treatment) — Date

CMC Family Medicine - PeachView — 864-489-2400
Approved Physician for treatment — Phone

NOTE: This is not an acceptance of liability.

Return to Work Notice
(To be completed by Doctor after examining employee)

Name of Doctor's Office/Clinic _____

Location _____ Phone _____

Diagnosis _____

☐ Employee **IS** able to return to regular duties at this time.

☐ Employee **IS** able to return to light duties at this time, **list limitations**: _____

_____

☐ Employee **IS NOT** able to return to work at this time because: _____

_____

_____ — _____
Request Referral to: (if applicable) — Follow-up appointment date

_____ — _____
Signature (Doctor) — Date

Administrator or Supervisor completes

Cherokee County School District
Employee Job Related Injury Form 1-A

(To be completed by Building Administrator/Supervisor)

Employee Information			
Name (Last, First, Middle Initial)	Social Security Number		Telephone Number
Address	Occupation		School/Department
City, State, Zip	Number hours worked (day/week)	Time Employee Began Work _____AM_____PM	How long at current position

Occurrence/Treatment			
Location/Department Accident Occurred	Date of Accident/Illness	Time Incident Occurred _____AM _____PM	
Specific activity the employee was engaged in when accident/illness occurred			
Type of Injury/Illness	Body Part Affected		
Date/Time Employer Notified	Last Date Worked	Date Returned to Work	Number of Days Missed Due to Injury

Describe in Detail Nature of Injury (Include part of body affected, e.g. amputation of right index finger at 2nd joint, fractured arm, lead poisoning, etc)

Describe Employee's Activities when Injury Occurred w/Details of How Event Occurred (e.g. Operating drill press, saw, driving tractor, activity on playground, mopping kitchen, etc.)

Witness (Name, Address, Telephone Number)

_____Please check here if the Employee is seeking medical treatment at this time.

_____Please check here if the Employee has **declined** medical treatment at this time.

Attending Physicians (Name & Address)

CMC Family Medicine Peachview
(864-489-2400)
101 Professional Park
Gaffney SC 29341

Cherokee Medical Center
(864-487-4271)
1530 N Limestone St
Gaffney SC 29340

_____ Please Check if Services Rendered at:

(Please list hospital Name, Address and telephone number)

_____

_____

_____

I certify that the above information is true and correct

_____
Employee Name (Please Print)

_____
Employee Signature **Date**

Sworn to and subscribed to me before this date

Date _____

_____
Supervisor Name (Please Print)

_____
Supervisor Signature

Please scan and e-mail all completed forms to chad.palmer@cherokee1.org or fax to 864-902-3524

Any witness to the injury MUST complete a Witness Statement!

Cherokee County School District

Workers' Compensation

Witness Statement

To be completed by all witnesses.

Name of injured party: _____

Your Name: _____ **Age:** _____

Your Address: _____

Phone Number: _____ **Job Title:** _____

How long have you worked for the district? _____

How long have you known the injured party? _____

*******Did you see the incident occur?** _____

If you saw the incident occur, how did it happen? _____

_____

What body part(s) was injured in the incident? _____

If you did not see the incident, when were you first aware of the injury? _____

Who told you about the incident? _____

Did the employee report the injury to his/her Supervisor at the time of the incident? _____

Name of your Supervisor: _____

Do you know of any other witnesses to this injury? _____

If yes, please list their names:

_____

Is there any other information you feel should be considered in evaluating this claim?

_____

_____

By signing this witness statement, I acknowledge the information I have provided is true and accurate to the best of my ability.

Witnesses Signature: _____ **Date:** _____

Please scan and e-mail all completed forms to chad.palmer@cherokee1.org or fax to 864-902-3524