Forsyth County Schools Workers' Comp Claims Procedure:

Complete Forms 1-4 for every claim requiring medical care (4 pages)

Complete Forms 1 and 5 for claims that DO NOT require medical care (3 pages)

Form 1 – Employee Accident/Illness Report (PAGE 1)

It is extremely important that injuries are reported immediately! The more information we have at the time of injury the better.

The injured employee will complete PAGE 1 of the Accident Report and needs to be specific in their description of their injured body part (indicate whether it is the right or left side, if applicable). They also need to **shade in the body part on the diagram to better clarify the injured body part**. Make sure they indicate whether they return back to work, go home or go to a panel doctor. **And, PLEASE ENSURE THAT THE EMPLOYEE ANSWERS ALL 6 QUESTIONS.**

Form 1 – Supervisor/Administrator Report (PAGE 2)

Each accident report must be signed off on by the employee's supervisor and/or an administrator. Please have the supervisor or administrator complete this section within 72 hours of the accident. Once complete fax to 770-888-1221 or email to workerscomp@forsyth.k12.ga.us.

Form 2 – The Panel of Physicians

The law requires us to (1) POST the Panel of Physicians at every location and; (2) EXPLAIN to the employee their right to choose a physician from the panel. In addition to posting the panel you should have a copy of the panel in your accident kit.

When you present the panel to the employee, we ask that you **have the injured employee circle their physician selection and sign beside their selection affirming that we showed them the panel and gave them choice of physicians from the panel**.

Form 3 - The Bill of Rights

This form is created by the State Board of Workers' Compensation. It should be posted next to the Panel of Physicians. Please give a copy of this Bill of Rights to every employee at the time of accident.

Form 4 – The WC-207

This is the Release for Medical Records Form which is required for all employees filing a workers' compensation claim. **The employee must complete and sign this at the time of the accident**.

Form 5 – The Refusal of Medical Treatment or Observation Form

ONLY complete Form 5 if it is a minor incident and the employee refuses medical treatment. If you think their injury is severe then you should contact the Finance Department for special handling instructions.

Once complete all forms need to be sent to Sheila Fairfield in the Finance Department. Fax (770) 888-1221 or workerscomp@forsyth.k12.ga.us. Questions? Please call (770) 887-2461 x 202140.

EMPLOYEE ACCIDENT / ILLNESS REPORT

Please Complete All the Questions

(Revised July 2020)

Notice Regarding Worker's Compensation Eligibility: The injured employee or his/her immediate supervisor must complete and submit this accident report to the designee of the Principal or Facility Supervisor within 24 hours after the accident; AND the injured employee must see a physician designated as a Forsyth County Board of Education Worker's Compensation physician within 48 hours after the accident, OR if the injury occurred after doctor's hours and the injury requires immediate medical attention, the injured employee must report to the nearest emergency room.

Directions for the Employee and Principal or Facility Supervisor: **Retain Original at School/Facility Fax Copy to Finance Office (Fax 770-888-1221)**
(1) ALL employee accidents must be reported verbally to the Finance Department (770-887-2461 x 202140) ASAP by your designee
(2) Direct the injured employee or his/her immediate supervisor to complete and return this accident report to your designee within 24 hours; (770-888-1221)
(3) Take appropriate corrective action designed to prevent or reduce the risk of a similar accident whether with Facilities or Transportation

Information about the Accident

School or Facility Name:_____ Accident Date:_____ Accident Time:_____ AM/PM

Full Name of Person Involved in the Accident:_____

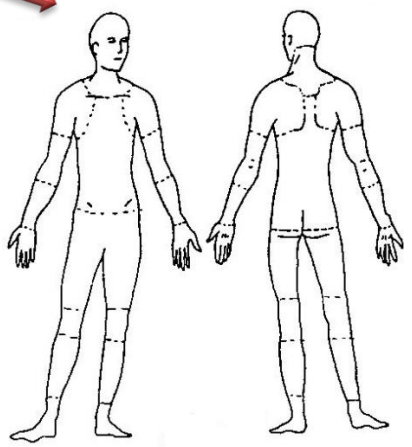
Cell Number of Person Involved in Accident:_____ Email of Person Involved in Accident:_____

When did the supervisor/administrator first have knowledge of the injury? Accident Date:_____ Accident Time:_____ AM/PM

Check all that Apply:
Location of Occurrence: ( )On Premises ( )Off Premises ( )On Approved Route
Job Description: ( )Teacher/Administrator ( )Secretary/Clerk ( )Custodian ( )Food Service ( )Maintenance ( )Bus Driver ( )Other
(Specify Other)_____

Nature of Injury/Illness: (Strain, Laceration, Burn, Fracture, etc.) _____

Part(s) of Body: (Back, Finger, Hand, Foot, etc.)_____ **(Shade in body part)**



Employee Went ( )Back to Work ( )Home ( )To Panel Doctor ( )To Hospital ( )**Nurse** ( )**Other**

If **Nurse** or **Other** give details: _____

1. **Please describe the accident (be as descriptive as possible including where the accident happened):**
   _____
   _____
   _____
2. **Have you had prior injury or condition to injured body part(s)? Yes ☐ No ☐ If yes, explain:**
   _____
3. **Did you have any medical conditions before the accident? Yes ☐ No ☐ If yes, explain:**
   _____
   _____
4. **Did anyone witness the accident? Yes ☐ No ☐ If yes, give details:**
   _____
5. **What could have been done to prevent the injury?**
   _____
6. **Did you select a doctor from our panel of physicians? Yes ☐ Incident Only ☐ If incident only, state why you do not want to seek treatment:**
   _____

Employee Signature:_____ Date: _____

Immediate Supervisor Signature (if applicable):_____ Date:_____

Principal or Facility Supervisor Signature:_____ Date: _____

Forsyth County Schools Supervisor/Administrator Report

(Revised July 2019)

To Be Conducted by the School Safety Coordinator or Another Administrator. Please complete within 72 hours.

MANAGER REPORT

Injured Employee Name:_____ Date of Injury: _____

Medical: Did the employee receive treatment outside of our posted panel of physicians? Yes ☐ No ☐

If YES, did the employee go to the emergency room? Yes ☐ No ☐

Emergency Room: _____

Why did the employee go to the emergency room?

_____

If NO, where did employee go for medical treatment (we need to know why they did not go to a panel doctor):

_____

Did the employee go alone to seek medical treatment? Yes ☐ No ☐ If NO, who went?_____

Red Flag Analysis (please give an explanation for every box checked) **If no Red Flags check here** ☐

☐ There were conflicting descriptions of what happened.

☐ The employee had health concerns that may have contributed to the incident.

☐ The employee had a history of injuries

☐ The employee had missed days or reported sick prior to the injury

☐ The claim was unwitnessed. If No were witness statements obtained? Yes ☐ No ☐

☐ The employee has had previous workers' compensation claims.

☐ The employee delayed reporting.

☐ The Supervisor delayed reporting.

☐ The employee works somewhere else.

☐ The employee may have been injured away from work.

☐ The employee has had a history of disciplinary actions.

How Can Future Accidents Be Prevented? (Mark all that apply)

Employee Training_____Proper Use of Equipment___Improve Task Procedures_____Improve Work Area _____ Equipment Correction_____Removal of Hazard_____Use of Personal Protective Equipment_____Provide Hazard Warning_____Enforce Policy/Rule_____Other_____Explain: _____

_____ _____ _____

Name **Signature** **Date**

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible. (See Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

FORSYTH COUNTY SCHOOL SYSTEM - 6/2021

Peachtree Orthopedics **Hal Silcox III, MD** ***(Orthopedic Surgery)*** Lumbar **Donald F. Langenbeck, MD** ***(Physical Medicine & Rehabilitation)*** **John Chao, M.D.** ***(Orthopedic Surgery)*** Foot **Timothy Griffith, M.D.** ***(Orthopedic Surgery)*** Upper Extremity **Neil Tarabadkar, MD** ***(Orthopedic Surgery)*** Hand and Wrist	**2860 Ronald Regan Blvd** **Cumming, GA 30041**	**770.977.7777**
The Hand & Upper Extremity Center of Georgia PC Joshua Ratner ***(Orthopedic Surgery)*** Upper Extremity	**3400 Old Milton Pkwy #350** **Alpharetta, GA 30005**	**404.255.0226**
Resurgens Orthopaedics **Robert K Yarbrough** ***(Orthopedic Surgery)*** Hip and Knee	**4150 Deputy Bill Cantrell Memorial Rd #300** **Cumming, GA 30040**	**404.531.8484**
Hogan Healthcare Center ***(Orthopedic Surgery)*** General Ortho	**107 Colony Park Dr #100** **Cumming, GA 30040**	**770.456.5817**
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Northside Urgent Care – Dawsonville ***(Urgent Care)***	**81 Northside Dawson Dr #100** **Dawsonville, GA 30534**	**706.216.6000**

(Additional doctors may be added on a separate sheet)
The insurance company providing coverage for this business under the Workers' Compensation Law is:

FORSYTH COUNTY SCHOOL SYSTEM

Administered by: Georgia Administrative Services, Inc. 1775 Spectrum Drive, Suite 100 Lawrenceville, GA 30043 - Phone: 800/421-0710 Fax: 770/963-5754

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT

http://www.sbwc.georgia.gov

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

WC-P1 (7/2006)

Please have your Forsyth County School ID Badge when seeking medical treatment.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. § 34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.

2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.

3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occuring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catostrophic in nature you may be entitled to lifetime medical benefits.

4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.

5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $675 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.

6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $675 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $450 per week, not to exceed 350 weeks.

7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $450 per week for no longer than 350 weeks.

8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $675 per week. A widowed spouse with no children will be paid a maximum of $270,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.

2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.

3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.

4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.

5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.

6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.

7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.

8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.

10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.

11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.

12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: http://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov
Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los limites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas indústriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un tambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Compensación de Trabajadores
270 Peachtree Street, N.W. Atlanta, Georgia 30303-1299
404-656-3818 or 1-800-533-0682
http://www.sbwc.georgia.gov

FORSYTH COUNTY SCHOOL SYSTEM -
6/2021

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(Médicos adicionales pueden ser agregados en una hoja separada.) La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

FORSYTH COUNTY SCHOOL SYSTEM
Administered by: Georgia Administrative Services, Inc. 1775 Spectrum Drive, Suite 100 Lawrenceville, GA 30043 - Phone: 800/421-0710 Fax: 770/963-5754

Si usted tiene preguntas llame al (404) 656-3818 o 1-800-533-0682 o visita sitio web: http://www.sbwc.georgia.gov.

Hacer falsos testimonios voluntariamente con el propósito de obtener o negar beneficios es un crimen sujeto a penalidades de hasta 10,000.00 por violación (O.C.G.A. § 34-9-18 y § 34-9-19.)

WC-P1 (7/2006)

Tenga su credencial de identificación de la escuela del condado de Forsyth cuando busque tratamiento médico.

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. § 34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.

2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.

3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente occurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si un lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.

4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.

5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $675 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.

6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no mas de $675 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $450 por semana, que no excedan 350 semanas.

7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no mas de $450 por semana pero no más de 350 semanas.

8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $675 por semana. Una esposa viuda sin niños se le pagara un máximo de $270,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.

9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.

2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.

3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.

4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.

5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.

6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.

7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.

8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.

9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.

10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.

11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.

12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: http://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

SI USTED TIENE PREGUNTAS LLAME AL 404-656-3818 O 1-800-533-0682 O VISITA SITIO WEB http://www.sbwc.georgia.gov
CUALQUIER DECLARACIÓN FALSA Y DELIBERADA PARA OBTENER O NEGAR BENEFICIOS ES UNA OFENSA CRIMINAL Y ES SUJETO A PENALIDADES DE HASTA $10,000 POR CADA VIOLATIÓN (O.C.G.A. § 34-9-18 and § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
SSN	Date of Injury	Birthdate

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to Georgia Administrative Services, Inc./Forsyth County Schools in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(1) which reads as follows: *"The covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

Refusal of Medical Treatment or Observation
Forsyth County Schools Workers' Compensation

Employee Name: _____

Date of Injury: _____ Time of Injury: _____

Date Reported: _____ Location of Incident: _

Supervisor(s): _____

Witness(es): _____

I,_____, hereby acknowledge that my supervisor(s) has offered and made available to me an opportunity to seek necessary medical treatment and/or observation at the expense of my employer, Forsyth County Schools (FCS), for the work-related injury I incurred on _____ (Date). I am voluntarily choosing to decline medical treatment and/or observation at this time.

I understand that I may request from my employer, at a later time, authorization to obtain medical treatment and/or observation for the injury described above. However, I understand that my refusal of medical treatment and/or observation today may impact my eligibility for workers' compensation benefits related to the injury described above. If I do decide at a later time to seek medical treatment I understand that I must let FCS know and if treatment is authorized I must treat from a physician located on our posted panel of physicians.

_____ _____

Employee Signature Date

_____ _____

Witness Date