WORKERS' COMPENSATION
INJURY PROCEDURE

In the event of a workplace injury, please follow these steps.

1. **Seek appropriate Medical Attention. If it is a life threatening emergency, please go to Morehouse General Hospital or the hospital of your choice. If it is not life threatening, please go to your general physician (if they receive w/c). Below is a list of physicians that see workers compensation.**
2. **Report the injury to your supervisor immediately!**
3. **Your supervisor must complete the Employer Report and you will need to complete the Statement of Injury, Employee Certificate of Compliance, and the Payment Options form. (Even if it is a Report Only!)**
4. **Please complete these forms and fax to 318-281-5956. <u>It is critical to report the injury immediately</u>. I really need this the same day of the injury, if possible.**

******In accordance with school policy, injured workers are subject to a post accident drug testing.******

LUBA Casualty Insurance Company (028)
PO Box 98082
Baton Rouge, Louisiana 70898-9082
Phone (888) 884-5822
Fax (225) 389-9333

Morehouse Parish School Board Policy #028000018442111

If you sustain an injury after hours and need guidance, please call John Files at 282-6211.

Dr. Netherland
427 S Vine Street
Bastrop, Louisiana 71220
318-556-3333

St. Francis Occupational Medical Clinic
920 Oliver Rd Suite 1400
Monroe, LA 71201
318-966-6320

MAIL TO:
WORKERS' COMPENSATION INSURER

_____ - ____ - _____
Employee Social Security Number

_____
Employer UI Account Number

Employer Federal ID Number

EMPLOYER REPORT OF INJURY/ILLNESS

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
- ☐ Injury resulted in death
- ☐ Amputation or disfigurement
- ☐ Possible dispute
- ☐ Lump Sum Compromise/Settlement
- ☐ Other
- ☐ Medical only (DO NOT mail copy to OWCA)

1.Date ofReport MM/DD/YY	2. Date / time of Injury MM/DD/YY Time ☐AM ☐PM	3. Normal Starting Time Day of Accident ☐AM ☐PM	4. If Back toWork - Give date MM/DD/YY	5. At same wage? ☐Yes ☐No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY		Date Received
10. Employee Name First Middle Last		11. ☐ Male ☐ Female	12. Employee Phone # ( )		Naics:.
13. Address and Zip Code			14. Parish of Injury		State-Parish
15. Date of Hire	16. Date of Birth	17. Occupation	18. Dept/Division Employed		Occupation
19. Place of Injury-Employer's Premises ? ☐Yes ☐No	20. If No, Indicate Location-Street, City, Parish and State				Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body
					Source
					Event
					NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)					24. If Occ. Disease-Give Date Diagnosed
25. Physician and Address			26. If Hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report - Please print		
29. Employer's Address and Zip Code			30. Employer's Telephone Number ( )		
31. Employer's Mailing Address-If Different From Above			32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information (optional) Employee was paid ☐ Daily ☐ Weekly ☐ Monthly ☐ Other. The average weekly wage was $_____ per week.					

LWC-WC-1007 Insurer Name:
Rev: 07/08 Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address:

Download Employer's Certificate of Compliance

STATEMENT OF INJURED

Name	Telephone	Married or single
Address	Occupation	Average weekly wage
Employer's name and address		

Date of birth	Social Security number	Height	Weight	Right- or left-handed
Names and ages of dependents				

Date of accident	Hour AM ❑ PM ❑	Place of accident

Describe in detail what you were doing and what happened when the accident occurred

Continue on separate sheet, if necessary

Describe your injury

Names and addresses of witnesses or person(s) having knowledge of accident

Name and address of attending physician

Date of first visit	If seen by another physician(s), name(s) and address(es)

If still receiving treatment, how often do you visit your physician?	Did you lose time from work because of your injury? Yes ❑ No ❑

Last day worked	Have you returned to work? Yes ❑ No ❑	If so, what date?	At what wage?

If still disabled, state present condition	When do you expect to return to work?

Have you ever had a previous injury resulting in permanent or partial disability? If so, describe.

Date	Signed (signature of injured person)

This authorization or photocopy thereof will authorize you to give the Claims Center or its representative all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and physical findings, diagnosis and prognosis.

I understand that the receipt of temporary total disability benefits while I am working in any employment (including self-employment) is insurance fraud, punishable as a felony offense.

Date _____ **Signed** _____

(Signature of injured person)

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P.O. Box 98082
Baton Rouge, Louisiana 70898-9082
Phone: (888) 884-5822
Fax: (225) 389-9333

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CC0238E/S REV 12/10 (06-584)

EMPLOYEE
CERTIFICATE OF COMPLIANCE

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation **benefits may be suspended if you do not timely submit this Certification.** You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to $10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

Unlawful Benefits Paid or Claimed	Fine	Imprisonment
$10,000 or more	up to $10,000	up to 10 years, with or without hard labor
$2,500 or more but less than $10,000	up to $ 5,000	up to 5 years, with or without hard labor
less than $2,500	up to $500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000 and may forfeit your right to receive workers' compensation benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

Print Name _____ Signature _____ Social Security Number _____ Date _____

Address _____ City _____ State / Zip _____ ( ) Phone Number _____

Note: Only one copy is required per case from the employee.

Please mail this form to your employer or your employer's insurer.

LWC-WC-1025.EE
REVISED 07/2008

MOREHOUSE PARISH SCHOOL BOARD

718 SOUTH WASHINGTON STREET
POST OFFICE BOX 872
BASTROP, LA 71221-0872
PHONE: 318 281 5784 FAX: 318 281 9919

Workers' compensation payment options

1. **Workers comp benefits only**

   The employee would be paid 65% of earned salary with a maximum benefit per week of $522.00. To receive full retirement credit, - the employee must contribute their normal share, which is 8%, to the retirement system and pay the normal deducted insurance or other type deductions. (The employee will not receive a paycheck from MPSB)

2. **Workers Benefits with a co-ordination of accumulated sick leave**

   The employee would receive worker's comp benefits at 65 % of normal pay or the maximum of $522.00 per week and utilize accumulated sick leave to receive normal pay. The normal employee contribution to the retirement system would be deducted from the school board payroll check, and paid to the retirement system to accrue service credit. If other payroll deductions are unable to be paid, the employee will be responsible for paying these to the school board in order to continue benefits.

3. **Use of Accumulated Sick Leave only**

   If the employee has accumulated enough sick days to cover the time away from work, the employee may opt to use these days to receive full pay. All other deductions and benefits would continue as normal, including retirement credit.

4. **A co-ordination of workers' comp benefits, accumulated leave, extended leave, and disability benefits.**

   To receive full pay when hurt on the job, the employee may utilize all benefits in order to receive full pay if possible. Worker's comp will only pay 65% of the employees' salary to the maximum benefit. If all accumulated leave is used, extended leave may also be used calculated at an hourly rate, since extended leave pays 65 % of salary. The employee may also file a disability claim, if enrolled in the coverage to receive 10% of your disability benefit under co-ordination of benefits.

Please select your option and return to La Donna or Robyn in the Personnel building.

I select option _____.

Sign: _____ Date: _____

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of $500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to $10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than $500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to $10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to $5,000.

EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)	Signature Date
Company Name	Company Address
( ) Phone Number	Insurance Policy Number
Employee Name	- - Employee Social Security Number

HP Officejet 6310v
Personal Printer/Fax/Copier/Scanner

Log for
Morehouse Parish School B
3182815956
Jul 10 2012 11:27AM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
Jul 10	11:24AM	Fax Sent	2831846	3:04	8	OK

Morehouse Parish School Board

Personnel Services

P.O. Box 872
4099 Naff Street
Bastrop, LA 71221-0872
(318)283-3408
Fax (318)281-5956

Tom Thrower, Superintendent

Dorothy Wheeler, Personnel Supervisor

FAX

TO: Dolly Martin

FAX:

FROM: LaDonna M.

FAX: 318-281-5956

DATE: 7/10/2012

TIME:

Pages to follow: 7

Message/Instructions: Workers Comp Form

HP Officejet 6310v
Personal Printer/Fax/Copier/Scanner

Log for
Morehouse Parish School B
3182815956
Jul 10 2012 11:02AM

Last Transaction

Date	Time	Type	Station ID	Duration	Pages	Result
Jul 10	10:59AM	Fax Sent	2831846	2:52	7	OK