Workers' Compensation

Reporting Instructions for Supervisor

- Ensure that the employee fills out all required documentation. The following forms will need to be completed. **Workers Compensation First report of Injury, Leave Election Payment Form, Authorization and Consent to release information, and the Albany State University Employee Report of Injury form**. (These forms may also be supplied by the Benefits Coordinator if needed)
- For accident reporting and filing a workers' compensation claim, **dial 1-877-656-RISK (7475).**
    - Claims must be reported exclusively by a Supervisor.
    - Employees are not permitted to initiate their own claims.
- Please have the following information ready when speaking with the representative:
    - Name and Address of the Injured Employee
    - Name, Address, and Telephone Number of the Employing
    - Social Security Number of the Injured Employee
    - Age and Sex of the Injured Employee
    - Date and Time of the Accident
    - Description of the Accident (including how, where, and why it occurred)
    - Type of Injury (e.g., cut, scrape, burn, etc.)
    - Exact Part of the Body Injured
    - Hourly/Weekly/Monthly Wage of the Injured Employee
    - Name and Address of the Physician/Hospital
    - Has the Injured Employee Returned to Work?
- While on the call, the representative will furnish you with a Worker's Comp Claim Number, for example, **WC##########. Please record this number on the Report of Injury Form.**
- Provide the claim number to the injured employee and instruct them to contact an AmeriSys Case Manager at 404-554-8300, selecting option 2, to schedule a doctor's appointment if necessary.
- **Note: Please allow 30 minutes for the claim to be processed before making the call.**
- Supervisors must report injuries within 24 hours of an accident.
- Reporting can only be delayed briefly if the supervisor needs to take the employee to the doctor.
- After a claim has been reported through the Telephonic Reporting System, any adjustments to the provided information should be communicated by contacting your assigned DOAS Workers' Compensation Specialist.
- Within 24 hours of the report, a copy of the completed **Workers Compensation First report of Injury, Leave Election Payment Form, Authorization and Consent to release information, and the Albany State University Employee Report of Injury form** will need to be forwarded to the Human Resources Department or your Benefits Coordinator.
- **Note: Injuries requiring only first aid or requiring no medical care should be recorded within the agency as an incident only.**

REPORT OF INJURY OR OCCUPATIONAL DISEASE

☐ **No medical attention**
(Do not call in)

☐ **Medical attention required**
(Call to report)

Employee personal information

Employee's last name	Employee's first name	M.I.	Employee's Social Securiy Number	Date of injury

Employee gender ☐ Male ☐ Female	Employee's birthdate	Employee's cellphone number

Date hired by employer ★	Employee's department work number

Employee's email	Employee's complete home mailing address (including city, state, zip)

Employer

Albany State University 7210
Employee Benefits Dept.
Human Resources Building
2400 Gillionville Road
Albany, GA 31707

Supervisor name	Supervisor phone number

Supervisor email

Employee injury and employment information

Number of days worked per week	List normally scheduled days off	Enter first date employee failed to work a full day, if applicable	Wage rate at time of injury or illness ☐ Per hour ☐ Per day ☐ Per week ☐ Per month

Time of injury ☐ am ☐ pm	Date employer had knowledge of injury	Did employee receive full pay on date of injury? ☐ Yes ☐ No

Did illness/injury occur on employer's premises? ☐ Yes ☐ No	Type of illness/injury	Body part(s) affected

How injury or illness occurred:

Treating physician (name and address, if known)	Initial treatment given ☐ None ☐ Minor: By employee ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24 hrs	Hospital/treating facility (name and address, if known)	If returned to work, give date: Returned at what wage per week If fatal, enter date of death

Report prepared by (Print or type)	Telephone number of reporting person	Date of Report

✔ If medical attention is needed, call the reporting center: 1-877-656-7475. If emergency treatment is needed, handle that first!

✔ To arrange medical treatment (after the supervisor has called the reporting center), the employee may call 1-800-900-1582 to speak to a Nurse Case Manager with Amerisys regarding his/her case.

✔ If no medical attention is required, file this document in departmental files.

Leave Election and Workers' Compensation Payment Election Form

Clear form - all 4 pages

Date _____

Injured employee _____

Social Security # _____

I was injured on the job on (date) _____

while working for the Department of _____
at the Albany State University.
If I have to lose any work time because of this injury, I request payment as follows (check one of the following):

☐ From my accumulated sick leave, and if necessary, from accumulated annual leave, before receiving Workers' Compensation benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive Workers' Compensation benefits if I am still unable to return to work.

☐ Workers' Compensation benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular bi-weekly installments.

☐ Accrued leave through this date: _____. Afterwards, I would like to be paid Workers' Compensation benefits for loss of wages instead of full pay.

I have carefully considered the decision I have made regarding compensation for lost work time because of this injury. By my signature below, I certify that I understand the decision I have indicated is irrevocable after the first payment is made (either Workers' Compensation or leave payment).

I understand that I am not eligible to receive Workers' Compensation wages until I have been out of work for seven (7) days (which may include one weekend), with payments beginning on the eighth (8th) day.

Method for receiving benefit

The default method for receiving a benefit is pre-loaded VISA debit card. The first benefit payment will be made by paper check. After that, if no other choice is made, the employee will receive the pre-loaded debit card. The debit card can be loaded with the benefit payment on an ongoing basis. The only other method for receiving a benefit is direct deposit to the employee's checking/savings account.

☐ I wish to receive my benefit via VISA debit card

☐ I wish to receive my benefit deposited to my bank account.

✔ **If you want direct deposit, you MUST attached a voided check to this form.**

_____
Signature of injured employee as shown on payroll

If an "X" or mark is used as the signature, two (2) witnesses are required.

(1) _____

(2) _____

Clear form - all 4 pages

WC-207 AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

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

TO:		
Print Name and Title		
D.O.A.S. Risk Management Services		
Address		
200 Piedmont Ave SE Suite 1208 West Tower		
City	State	Zip Code
Atlanta,	GA	30334

RE: Employee / Patient		
Last Name	First Name	M.I.
Social Security Number	Date of Injury	Birthdate

This document authorizes the release of only those medical records related to the injury which is the subject of this claim for workers' compensation benefits and may be required at any time during the pendency of the claim. The above-stated entity, facility or medical practitioner is authorized to release

information to **DEPARTMENT OF ADMINISTRATIVE SERVICES** 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:

> "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. Notwithstanding any other provisions 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."
>
> "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 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. Said release shall designate the provider and shall state that it will expire on the date of the hearing. If the employee refuses to provide a signed release for medical information as required by this subsection, any weekly income benefits being received by the employee shall be suspended and no hearing shall be scheduled at the request of the employee until such signed release is provided."

The patient completely releases the entity, facility, or medical practitioner from any and all liability which may result or could result from the release of such information. This release is in compliance with Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 document receives the same under all protection of Federal and State law inuring to the patient.

This release shall expire in 90 days or upon written notice of revocation by the patient, whichever is later. If a hearing is pending, this release shall remain in effect until 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).