Westminster Public Schools
Where Education is Personal

WORKERS' COMPENSATION PROCEDURES

Frequently Asked Questions

Q. What happens if an employee is injured on the job?

A. An employee should immediately report all work-related injuries, illnesses, or occupational disease exposures to their supervisor/administrator in writing within four working days.

Q. Who to contact?

A. Human Resources receives all employee injury claims. You may contact Rongene Wilcox, (720) 542-5013 or rwilcox@westminsterpublicschools.org, or Joyce Marquez, (720) 542-5068 or jmarquez@westminsterpublicschools.org. Forms should be faxed to (303) 657-3938. If an employee has an open claim and needs to contact the third party claims administrator, Canon Cochran Management Services, Inc. (CCMSI), they can be reached at (303) 804-2000.

Q. What forms need to be completed and by whom?

A. At the time of the report, both the employee and the supervisor/administrator must complete forms that are essential to the claims process.

The employee is required to complete an *Employee's Accident Report (*Attachment A), *Permission for Release of Information* form (Attachment C), and *Workers' Compensation Authorization for Evaluation or Treatment & Designated Provider List form, (*Attachment D).

The supervisor/administrator is required to investigate the accident and state their perspective of the accident by completing a *Supervisor's Accident Report (*Attachment B). They must also sign *Employee's Accident Report (*Attachment A) and complete the *Workers' Compensation Authorization for Evaluation or Treatment & Designated Provider List form, (*Attachment D). Complete the top portion and ensure that the employee selects a doctor and signs the *Notice & Acknowledgement* portion.

Q. What happens to the forms?

A. The *Employee's Accident Report*, *Supervisor's Accident Report*, *Permission for Release of Information*, and the *Workers' Compensation Authorization for Evaluation or Treatment & Designated Provider List* forms are to be faxed to Human Resources at (303) 657-3938. Once faxed, mail the originals to Human Resources.

Q. What if medical treatment is needed?

A. In the event of a **non-emergency** injury, the employee will need to provide a copy of the completed *Workers' Compensation Authorization for Evaluation or Treatment & Designated Provider List* form *(*Attachment D) to one of the designated physicians at COMP, Peak Form Medical Clinic, or Aviation & Occupational Medicine. As a courtesy, the treating facility should be notified of an injured employee's anticipated arrival.

In the event of an **emergency** and/or if the injury occurred **after-hours**, then the employee should visit the nearest hospital emergency room. Follow-up care must be provided by a designated physician at COMP, Peak Form Medical Clinic, or Aviation & Occupational Medicine.

An employee may not seek care from a private doctor or unauthorized medical facility for non- emergency injuries or follow-up care without prior approval.

Q. Where can the designated physicians at COMP, Peak Form, & Aviation be found?

A. An employee **must** choose a designated provider at one of the following locations:

Colorado Occupational Medicine Physicians (COMP)	Peak Form Medical Clinic	Aviation & Occupational Medicine
8515 Pearl St., Suite 300 Thornton, CO 80229 (84th & Washington St.) (303) 853-8989	1093 E. Bridge St. Brighton, CO 80601 (CO-7 & E. Bridge St.) (303) 655-9005	6900 E. 47th Ave Drive, Suite 100 Denver, CO 80216 (I-70/I-270 & Quebec St.) (303) 333-4411
Michael R. Striplin, M.D./ Dee Jay Beach, D.O.	X.J. Ethan Moses, M.D.	Michael Ladwig, M.D.

Q. What if the injured employee has not been able to work?

A. If the injured employee misses work due to a work related injury, he/she must report progress to Human Resources and his/her supervisor/administrator after each follow-up visit.

Q. What if the injured employee has been released to return to work?

A. The injured employee must report to the Human Resources Department before returning to work. The employee is required to bring a *Physician's Report of Worker's Compensation Injury* form provided and signed by the physician. The supervisor/administrator will receive notification of the employee's authorization to return to work from Human Resources.

Revised November 1, 2016

WESTMINSTER PUBLIC SCHOOLS
EMPLOYEE WRITTEN NOTICE OF ACCIDENT

ATTACHMENT A

Pursuant to the Colorado Worker's Compensation Act 8-43-102: "Every employee who sustains an injury resulting from an accident shall notify said employee's employer in writing of the injury within four days of the occurrence of the injury." Failure to give timely notice may result in the loss of "up to one day's compensation for each day's failure to report."

1. Name of injured _____ S.S. # _____
   (First) (Middle) (Last)

2. Employee Address _____ Phone Number _____
   (No. & Street) (City) (State) (Zip)

3. No. of hours Worked per day _____ Days worked per week _____ Working shift From _____a.m. To _____p.m. Do You Work at Multiple Locations? _____Yes or _____NO

4. Occupation _____ Building(s)/School(s) _____

5. Was accident on employer's premises? _____

6. Place of accident _____
   (No. & Street) (City) (State) (Zip)

7. What were you doing at time of accident? _____

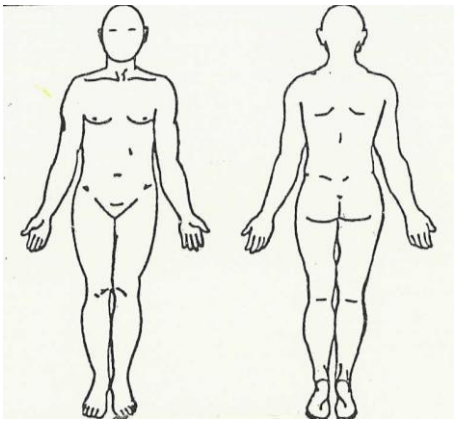
   _____
   Be specific as to the name and type of tools, equipment or material causing injury.

8. How did the injury occur? _____

   _____
   Describe fully the events which resulted in the injury. Give full details on all factors which led or contributed to the accident.

9. Describe the injury in detail and indicate on the diagram the part of the body affected.

   _____
   For example, injury to right index finger at second joint; upper or lower back, etc.



MARK INJURED AREA

10. DATE OF INJURY _____ 11. TIME OF INJURY _____

12. Did the injury cause the employee to see a physician? Yes _____ No_____

    Was one of the Designated Physicians seen for this injury? Yes _____No_____
    If no, give the name of physician seen:

    _____
    Name of Physician Address

    (Except for an emergency, your medical expenses will be paid only if you use a Designated Physician.)

13. Were you able to continue to work after the accident? Yes _____No_____

    If you missed any work, what date did you return to work? _____

14. Name of Witness _____ Address _____

    Name of Witness _____ Address _____

15. Date of report _____ Remarks _____

I acknowledge by my signature below that unless my injury is or was an emergency that I must see one of Westminster Public Schools' Designated Physicians for my injury or the bills will not be paid by the District. A list of Designated Physicians shall be provided by Westminster Public Schools as part of this claim reporting process.

_____ _____

(Signature of Employee) **(Signature of Building Principal or Supervisor)**

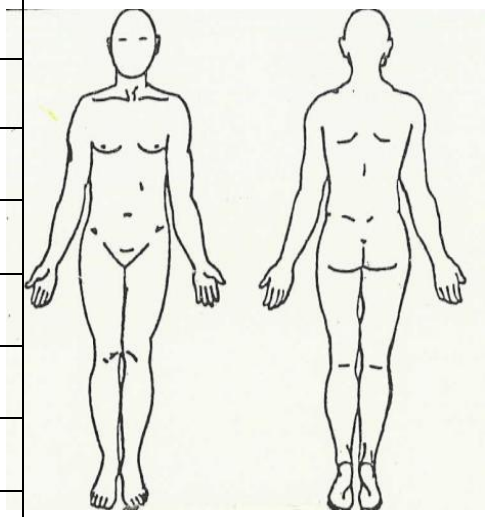
ATTACHMENT B

ROCKY MOUNTAIN RISK INSURANCE GROUP WORKERS' COMPENSATION
SUPERVISOR'S ACCIDENT REPORT SJ-1686

EMPLOYEE NAME		OCCUPATION	
EMPLOYEE PHONE NUMBER		BUILDING/SCHOOL	
ADDRESS			
INJURY DATE	DATE REPORTED	HOUR ☐ AM ☐ PM	WAS EMPLOYEE PERFORMING REGULAR JOB ☐ YES ☐ NO

NATURE AND EXTENT OF INJURY

DESCRIPTION AND LOCATION OF ACCIDENT



MARK INJURED AREA

WHAT CAUSED THE ACCIDENT

OUTSIDE MEDICAL ☐ YES ☐ NO

LOST TIME ☐ YES ☐ NO

WHAT STEPS HAVE BEEN TAKEN TO PREVENT A SIMILAR ACCIDENT

WITNESS(ES) NAME & JOB TITLE
1.
2.
3.
4.

SUPERVISOR'S NAME (PRINT)	SUPERVISOR SIGNATURE & DATE	DEPARTMENT	

ATTACHMENT C

PERMISSION FOR RELEASE OF INFORMATION

Dear Westminster Public Schools Employee:

In order to administer your workers' compensation benefit in an accurate and timely manner we need your permission to access pertinent medical and employment information. Please sign this release at the time you report injury to your employer. Westminster Public Schools workers' compensation claims are administered by:

Cannon Cochran Management Services, Inc. (CCMSI)
PO Box 4998
Greenwood Village, CO 80155
(303) 804-2000

You will be receiving information and forms from CCMSI. The information you provide will assist them in determining claim coverage.

Thank you for your cooperation in this matter.
Rocky Mountain Risk Insurance Group

I, _____, hereby consent and request that CCMSI, its successors, its agents, and employees, be permitted to examine and obtain copies of all hospital and medical records pertaining to the pre-placement, post-offer medical exam and to this and all past workers' compensation claims and/or injuries. I also permit and request CCMSI be allowed to interview doctors and other attendants regarding all matters relating to examination, diagnosis, care and treatment of myself for my current and all other workers' compensation claims. I also permit and request that CCMSI be allowed to obtain all medical records they deem necessary in order to investigate and manage my current claim for benefits.

I further consent and request that CCMSI be permitted to interview and correspond with all employers regarding all matters relating to my present and past employment, earnings, and loss of earnings. I also authorize release of all present and past employment records.

I further consent and request that CCMSI be permitted to interview and correspond with all disability plans and administrators regarding all matters relating to my disability benefits for my current and past claims. This authorization is valid for past and present workers' compensation claims or other claims for any and all types of disability benefits I have claimed including Social Security benefits.

A photocopy of this authorization shall have the same authority as the original.

Note: Workers' Compensation Requests are Exempt from HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

_____ ____/____/_____
Employee Signature Date

ATTACHMENT D

WESTMINSTER PUBLIC SCHOOLS

Workers' Compensation Authorization for Evaluation or Treatment & Designated Provider List

I. Workers' Compensation Authorization for Evaluation or Treatment (Injured employee must provide a copy of this form to treating provider if seeking medical treatment)

Employee Name: _____ Scheduled Work Hours _____

Authorized By: _____ Signature: _____

Date Sent In: _____ Time Sent In: _____ ☐ am ☐ pm Appointment Time: _____ ☐ am ☐ pm

Employer Contact:	Rongene Falasco-Wilcox, (720) 542-5013 Joyce Marquez, (720) 542-5068	Risk/ Facilities Safety Coordinator:	Darren Trujillo, (720) 542-5154
Employer Address:	Educational Services Center 6933 Raleigh Street, Westminster, CO 80030	Employer's Insurance:	Rocky Mountain Risk Insurance Group Third Party Administrator: CCMSI P.O. Box 4998 Greenwood Village, CO 80111 Phone: (303) 804-2000 Fax: (303) 804-2005

II. Designated Provider List (Injured employee MUST choose one physician)

In compliance with State Workers' Compensation rules, you, the injured employee **must** choose a Workers' Comp Medical Provider from one of the following authorized medical providers *(✓ the appropriate box)*:

Colorado Occupational Medicine Physicians (COMP) *8515 Pearl St., Suite 300* *Thornton, CO 80229* *(84th & Washington St.)* *Mon - Fri: 8:00 a.m. - 5:00 p.m.* *(303) 853-8989* ☐ Michael R. Striplin, M.D. ☐ Dee Jay Beach, D.O.	**Peak Form Medical Clinic** 1093 E. Bridge St. Brighton, CO 80601 *(CO-7 & E. Bridge St.)* *Mon - Fri: 8:00 a.m. - 5:00 p.m.* *(303) 655-9005* ☐ X.J. Ethan Moses, M.D.	**Aviation & Occupational Medicine** 6900 E. 47th Ave Drive, Suite 100 Denver, CO 80216 (I-70/I-270 & Quebec St.) *Mon - Fri: 8:00 a.m. - 5:00 p.m.* *(303) 333-4411* ☐ Michael Ladwig, M. D.

Note: In the case of an emergency situation, you should go to any physician or medical facility that is able to provide medical care. **Once the emergency has resolved, you must obtain all future medical care from the medical provider you have chosen.** If you are away from the usual place of employment at the time of the injury, you may be referred to a physician in the vicinity of the injury.

Notice & Acknowledgement

This list was provided to _____ by _____
(Injured Worker – Please Print) (District Rep – Please Print)

On _____ by ☐ Hand Delivery ☐ U.S. Mail ☐ Email ☐ Fax

_____ / / _____
Signature of Injured Worker **Date**

_____ / / _____
Signature of District Representative **Date**

Revised November 1, 2016