NO-CHARGE WORKERS' COMPENSATION GUIDELINES Revised 6-22-2017

When an employee is injured by an ESBOCES student/parent, the following must be adhered to:

Form	Submit to	Timeline: From Date of Injury	Comments
5320F.1 – *Employee Injury/Incident Report* – **Page 1**	Risk and Asset Management Office	1 Business Day	Submit page 1, completed and signed by employee, to Risk and Asset Management Office. Page 2, signed by Principal, can be submitted separately if necessary (see next line).
5320F.1 – *Employee Injury/Incident Report* – **Page 2**	Risk and Asset Management Office	5 Business Days	Submit form to Principal immediately for signature, then Principal will submit Page 2 to Risk and Asset Management Office within 5 business days.
Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider	Principal	1 Business Day	Submit with Form 5320F.1 to Building Principal or Administrator
Medical documentation as requested by Travelers Insurance Co.	Travelers Insurance Company	10 Business Days	Keep Copy

All forms referenced above can be accessed via the ESBOCES website *(esboces.org)* under the **FOR STAFF** tab.

It is the employee's responsibility to ensure that documentation is received by the Risk and Asset Management Office within the required timelines. It is strongly suggested that the forms are submitted using a method that provides proof of submission (scan and e-mail, fax, or hand deliver for date stamp) and that you keep copies of these documents for your own records.

- If the injury warrants medical attention, the employee must be seen by a healthcare professional under a physician's supervision. It is the employee's responsibility to obtain and submit the medical documentation required by Travelers Insurance company. The medical documentation must be received by Travelers Insurance Company from the employee within 10 business days from the date of injury.

- The Department of Human Resources may request further medical documentation as needed.

- The employee must continue to enter absences into AESOP as alleged Workers' Compensation. All time will be charged as SICK until adequate medical documentation is received.

- Teachers on approved no-charge time must continue to complete and maintain all classroom records, reports, and lesson plans.

- All employees are responsible for checking their ESBOCES e-mail on a daily basis, including those on no-charge time.

- The employee will be provided with a maximum of 180 school days (1 year), for qualifying absences related to a qualifying injury, starting from the date of injury. As an example, if an employee is injured on 12/1/2010, the opportunity to draw upon those 180 days concludes 11/30/2011. Any treatment/recovery time needed after that is charged at ½ Sick and ½ Workers' Compensation.

- No-charge time and compensation will end when the Workers' Compensation Board closes the employee's case, an independent medical examination determines that the employee is fit to return to work, after 180 school days, or on the date one year after the qualifying injury, whichever occurs first.

- After medical documentation is received by Travelers Insurance Company clearing an employee to return to work without restrictions, further no-charge time for any medical concern arising from the original injury will not be considered in the absence of re-documentation from a healthcare professional under a physician's supervision. If therapy services are required, appointments must be made either before or after the school day. Therapy sessions scheduled during the school day shall not be eligible for no-charge time.

- All no-charge cases may be reviewed by a committee and/or by the Agency's Workers' Compensation insurance carrier. The No-Charge Workers' Compensation Committee consists of equal administration and labor representation, including the unit President and/or designee. If the Committee cannot jointly reach a decision, the case will be brought to the Assistant Superintendent for Human Resources for review.

- At the determination of the Agency's Workers' Compensation insurance carrier, an additional signed statement from the injured employee may be required and taken by a representative of the insurance carrier. The Agency's Worker's Compensation insurance carrier may require an independent medical examination (IME), the expense of which is borne by the Agency. In the event that the IME determines that the employee is fit to return to work, the employee will be notified by the Department of Human Resources that his or her no-charge compensation and no-charge time will end. In the event the employee provides medical documentation that disputes the findings of the IME ordered by the insurance carrier, and except if otherwise precluded by law, the Agency will require that the employee undergo an IME by an Agency physician.

- The findings from the Agency IME will be evaluated and reviewed by the No-Charge Workers' Compensation Committee. If the Committee cannot jointly reach a decision to determine if payment and use of time for no-charge compensation will continue or terminate, the case will be brought to the Assistant Superintendent for Human Resources for review.

- In the event your claim is denied, you are entitled to appeal the decision. Submit your request for appeal to the Department of Human Resources along with any additional supporting documentation that you want considered during the appeal review. Appeals must be initiated by the employee and received by the Department of Human Resources within 30 days from the date of the Agency's communication of decision.

Eastern Suffolk BOCES

Educational Services That Transform Lives

Employee Injury/ Incident Report

Board of Cooperative Educational Services
First Supervisory District of Suffolk County
201 Sunrise Highway
Patchogue, NY 11772

PAGE 1 MUST BE COMPLETED, SIGNED BY EMPLOYEE AND SUPERVISOR, AND FORWARDED TO RISK AND ASSET MANAGEMENT OFFICE WITHIN 24 HOURS OF INCIDENT. PAGE 2 MUST THEN BE FORWARDED TO EMPLOYEE'S SUPERVISOR FOR COMPLETION.

SECTION 1

INJURED EMPLOYEE

Last Name _____ First Name _____ Home Telephone No. _____ Cell Telephone No. _____

Home Street Address _____ City _____ Zip _____

☐ Male ☐ Female

Date of Birth ___/___/___

Date of Hire ___/___/___

Job Title _____ Division _____

SECTION 2A

DESCRIPTION OF INCIDENT

Date of Incident ___/___/20___ Day of Week _____ ☐ AM ☐ PM Time of Incident

Location of Incident (Name of Building, Address, Room No., Etc. - **BE SPECIFIC**)

Description of Incident (State what you were doing at the time of the incident and what occurred.)

EXAMPLE: I was walking down the hallway and slipped on the floor.

Witnesses

SECTION 2B

Student Related ☐ Yes ☐ No Was student injured? ☐ Yes ☐ No If "Yes" complete Student Accident Report.

Type of Surface (Carpet, Dirt, Tile, Etc.) _____ Safety Devices in Use (Gloves, Safety Glasses, Etc.) _____

SECTION 3

NATURE OF INJURY

State the nature of the incident, what part(s) of the body were affected, and indicate right or left side (such as injury to the right ear, left elbow, thumb on right hand, resulting in bruises, swelling, etc.)

Was immediate medical care provided? ☐ Yes ☐ No If "Yes" when? _____

Immediate Medical Provider (Doctor, Ambulance No., Police Badge No., or Vehicle No., Etc.) (Optional)

Name and Address of Hospital (If Applicable)

Was work time lost beyond day of incident? ☐ Yes ☐ No

NY FRAUD STATUTE

The Insurance Law of the State of New York provides that any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

SECTION 4

Signature of Employee _____ ESBOCES Telephone No. _____

Title of Employee _____ Date of Report ___/___/20___

Signature of Supervisor (Acknowledges Receipt of Form) _____ Date Supervisor was Advised of Injury ___/___/20___

Signature of Building Administrator _____ Building Administrator's Telephone No. _____

Name of Employee _____ **Date of Incident** ____/____/____

THE FOLLOWING SECTION IS TO BE COMPLETED BY SUPERVISOR WITHIN FIVE (5) BUSINESS DAYS OF RECEIPT OF *EMPLOYEE INJURY/INCIDENT REPORT* AND FORWARDED TO RISK AND ASSET MANAGEMENT OFFICE – HINES ADMINISTRATION CENTER. DESCRIBE IN DETAIL THE TASK THE EMPLOYEE WAS COMPLETING AT THE TIME OF INJURY (INCLUDE VEHICLE, EQUIPMENT, OR TOOLS USED).

SECTION 5 – EMPLOYEE INJURY/INCIDENT REPORT ACCIDENT ANALYSIS

Interview witnesses or co-workers for additional insights, if necessary. ☐ Additional sheet attached for supplementary information/comments
Was this the employee's regular work assignment? ☐ Yes ☐ No

*** * * Any O checked in this section requires a comment. * * ***

Contributing Factors	Yes	No	N/A	Comments	Corrective Action
Environment					
1.1 Did the work area design contribute to the injury?	O	☐	☐		
1.2 Was the area cluttered?	O	☐	☐		
1.3 Did the employee have to be in this area to complete the job?	☐	O	☐		
1.4 Were other conditions (e.g., set floor, extreme temperatures, etc.) a contributing factor?	O	☐	☐		☐
1.4 Were there other environmental issues affecting safety? If so, what?	O	☐	☐		
Equipment/Tools					
2.1 Was the correct equipment being used?	☐	O	☐		
2.2 Was the correct equipment readily available?	☐	O	☐		
2.3 Did any defects or change in equipment/material contribute to hazardous conditions? If so, what?	O	☐	☐		☐
2.4 Is regular maintenance done on affected machinery/equipment?	☐	O	☐		
2.5 Was the employee using proper PPE (shoes, apron, goggles)?	☐	O	☐		
Method					
3.1 Was employee performing according to accepted work method?	☐	O	☐		
3.2 Was there a better method to perform the task? If so, what?	O	☐	☐		
3.3 Did employee comply with directives in student's IEP?	☐	O	☐		☐
3.4 Were CPI methods necessary?	O	☐	☐		
3.5 Were proper CPI methods used?	☐	O	☐		
Employee					
4.1 Was employee using all required safety equipment for task?	☐	O	☐		
4.2 Was employee trained on necessary equipment for the task?	☐	O	☐		
4.3 Was employee authorized to operate the equipment?	☐	O	☐		☐
4.4 Were required safety procedures being followed? If not, why?	☐	O	☐		
Management					
5.1 Were the behaviors that caused the injury/illness observed before?	O	☐	☐		
5.2 If so, what was done?					
5.3 Does management require specific safe work practices related to this task? If so, explain what was expected.	O	☐	☐		☐
5.4 Have safety related changes been made/suggested for this task?	O	☐	☐		

To correct unsafe acts: ☐ Review/change procedures ☐ Train/retrain injured employee ☐ Instruct all employees
☐ Other (Explain) _____

To correct unsafe conditions: ☐ Eliminate the hazard ☐ Request repairs ☐ Initiate ergonomic review
☐ Conduct periodic inspections

	Specific Corrective Actions	Assigned To	Date
1.			
2.			
3.			
4.			

_____ Signature of Supervisor

____/____/20____ Date

Original - Risk and Asset Management Office - Hines Administration Center
Copies - Insurance Carrier; Building Administrator; Employee

SOME POSSIBLE REMEDIAL ACTIONS FOR CLASSROOM-RELATED INJURIES

Cause of Injury	Possible Remedial Actions
Student Aggression	• Establish administrative protocol to ensure that all employees know their individual student plans before interaction; review periodically and obtain sign-off • Define and train employees in, and reinforce use of, basic best practices, such as maintaining adequate distance, keeping hair short or restrained, watching for distress clues, and requesting assistance before crisis develops
Slips/Falls – Wet Floors	• Establish guidelines for janitorial staff to provide sop mats at all entrances prior to facility opening during inclement weather • Establish guidelines for janitorial staff to patrol and clean entranceways more often during inclement weather • Establish a “Spill” code for the public announcement system to easily alert janitorial staff to spills and puddles • Establish a protocol for all employees to post a watch and/or place cones at any spill/puddle to guide others around until it can be cleaned
Slips/Trips/Falls – Housekeeping	• Train employees in, and reinforce use of, a plan to ensure a clear path before assisting to move/guide a student • Train/require employees to pick up after themselves and students to keep walkways clear
Strains/Sprains from Assisting Students	• Define and train employees in, and reinforce use of, proper techniques for assisting students when standing, sitting, toileting, walking, etc. • Provide adequate lifts, train employees in, and reinforce, proper use of lifts and mechanical aids as may be needed for students requiring high levels of assistance • Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person
General Strains/Sprains	• Define and train employees in, and reinforce, use of proper techniques for lifting, pushing, and pulling • Train employees in, and reinforce, proper use of machinery utilized by custodial staff • Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

_____ _____ _____ _____
Signature of Injured Employee Date Signature of Witness Date

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.