

## NO-CHARGE WORKERS' COMPENSATION GUIDELINES Revised 7-29-16

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

<b>Form</b>	<b>Submit to</b>	<b>Timeline: From Date of Injury</b>	<b>Comments</b>
5320F.1 – <i>Employee Injury/Incident Report – Page 1</i>	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 – <i>Employee Injury/Incident Report – Page 2</i>	Risk and Asset Management Office	5 Business Days	Submit form to Principal <u>immediately</u> for signature, then Principal will submit Page 2 to Risk and Asset Management Office within 5 business days.
<i>Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider</i>	Principal	1 Business Day	Submit with Form 5320F.1 to Building Principal or Administrator
5320F.2 – <i>Medical Records Release</i>	Physician		Submit to your Physician
5320F.4 – <i>No-Charge Workers' Compensation Medical Information Request</i>	Physician		Submit to your Physician
5320F.3 – <i>No-Charge Workers' Compensation Time Request</i>	Department of Human Resources	5 Business Days	Scan and e-mail OR fax to 631-289-2314 OR hand deliver to the Department of Human Resources
Note from Healthcare Professional Under Physician's Supervision	Department of Human Resources	10 Business Days	Keep Copy

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

**It is the employee's responsibility to ensure that the forms are received by the appropriate recipient 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 a note from a healthcare professional under a physician's supervision stating the date of injury, diagnosis, and prognosis. The note must be received by the Department of Human Resources 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 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.

**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.**

<b>SECTION 1</b>	<hr/>	<hr/>	<hr/>	<hr/>
<b>INJURED EMPLOYEE</b>	Last Name	First Name	Home Telephone No.	Cell Telephone No.
	<hr/>		<hr/>	<hr/>
	Home Street Address		City	Zip
	<input type="checkbox"/> Male	<input type="checkbox"/> Female	/ /	/ /
	Date of Birth		Date of Hire	
<hr/>		<hr/>		
	Job Title	Division		

<b>SECTION 2</b>	<hr/>	<hr/>	<input type="checkbox"/> AM <input type="checkbox"/> PM
<b>DESCRIPTION OF INCIDENT</b>	/ /20	Date of Incident	Day of Week
	Time of Incident		
	Location of Incident (Name of Building, Address, Room No., Etc. - <b>BE SPECIFIC</b> )		
	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.		
	<hr/>		
Witnesses			
<hr/>			
Type of Surface (Carpet, Dirt, Tile, Etc.)		Safety Devices in Use (Gloves, Safety Glasses, Etc.)	
Student Related <input type="checkbox"/> Yes <input type="checkbox"/> No		Was student injured? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" complete Student Accident Report.	

<b>SECTION 3</b>	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.)
<b>NATURE OF INJURY</b>	<hr/>
	<hr/>
	<hr/>
	<hr/>
	Was immediate medical care provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" when? <hr/>
	Immediate Medical Provider (Doctor, Ambulance No., Police Badge No., or Vehicle No., Etc.) (Optional)
	<hr/>
	Name and Address of Hospital (If Applicable)
	Was work time lost beyond day of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NY FRAUD STATUTE</b>	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.

<b>SECTION 4</b>	<hr/>	<hr/>
	Signature of Employee	ESBOCES Telephone No.
	<hr/>	/ /20
	Title of Employee	Date of Report
	<hr/>	/ /20
	Signature of Supervisor (Acknowledges Receipt of Form)	Date Supervisor was Advised of Injury
	<hr/>	<hr/>
	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. \* \* \***

**Environment**

Contributing Factors	Yes	No	N/A	Comments	Corrective Action
1.1 Did the work area design contribute to the injury?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.2 Was the area cluttered?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.3 Did the employee have to be in this area to complete the job?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
1.4 Were other conditions (e.g., set floor, extreme temperatures, etc.) a contributing factor?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
1.4 Were there other environmental issues affecting safety? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		

**Equipment/Tools**

2.1 Was the correct equipment being used?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.2 Was the correct equipment readily available?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.3 Did any defects or change in equipment/material contribute to hazardous conditions? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
2.4 Is regular maintenance done on affected machinery/equipment?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
2.5 Was the employee using proper PPE (shoes, apron, goggles)?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Method**

3.1 Was employee performing according to accepted work method?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
3.2 Was there a better method to perform the task? If so, what?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
3.3 Did employee comply with directives in student's IEP?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
3.4 Were CPI methods necessary?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
3.5 Were proper CPI methods used?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Employee**

4.1 Was employee using all required safety equipment for task?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
4.2 Was employee trained on necessary equipment for the task?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
4.3 Was employee authorized to operate the equipment?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		
4.4 Were required safety procedures being followed? If not, why?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>		

**Management**

5.1 Were the behaviors that caused the injury/illness observed before?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		
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.	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="checkbox"/>
5.4 Have safety related changes been made/suggested for this task?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>		

**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

**SOME POSSIBLE REMEDIAL ACTIONS FOR CLASSROOM-RELATED INJURIES**

<b>Cause of Injury</b>	<b>Possible Remedial Actions</b>
Student Aggression	<ul style="list-style-type: none"> <li>• Establish administrative protocol to ensure that all employees know their individual student plans before interaction; review periodically and obtain sign-off</li> <li>• 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</li> </ul>
Slips/Falls – Wet Floors	<ul style="list-style-type: none"> <li>• Establish guidelines for janitorial staff to provide sop mats at all entrances prior to facility opening during inclement weather</li> <li>• Establish guidelines for janitorial staff to patrol and clean entranceways more often during inclement weather</li> <li>• Establish a “Spill” code for the public announcement system to easily alert janitorial staff to spills and puddles</li> <li>• 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</li> </ul>
Slips/Trips/Falls – Housekeeping	<ul style="list-style-type: none"> <li>• Train employees in, and reinforce use of, a plan to ensure a clear path before assisting to move/guide a student</li> <li>• Train/require employees to pick up after themselves and students to keep walkways clear</li> </ul>
Strains/Sprains from Assisting Students	<ul style="list-style-type: none"> <li>• Define and train employees in, and reinforce use of, proper techniques for assisting students when standing, sitting, toileting, walking, etc.</li> <li>• 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</li> <li>• Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person</li> </ul>
General Strains/Sprains	<ul style="list-style-type: none"> <li>• Define and train employees in, and reinforce, use of proper techniques for lifting, pushing, and pulling</li> <li>• Train employees in, and reinforce, proper use of machinery utilized by custodial staff</li> <li>• Train/require employees to assess needs and obtain assistance from other employees when situation exceeds reasonable physical capabilities for one person</li> </ul>

**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.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.



<b>Medical Records Release</b>
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5320F.2  
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Board of Cooperative Educational Services  
First Supervisory District of Suffolk County  
201 Sunrise Highway  
Patchogue, NY 11772

To: \_\_\_\_\_

\_\_\_\_\_  
(Name and Address of Physician or Medical Institution)

Kindly furnish to Eastern Suffolk BOCES, Department of Human Resources, a copy of medical and/or psychiatric records relating to \_\_\_\_\_ from \_\_\_\_\_ / \_\_\_\_\_ /20\_\_\_\_ to date.

Name of Employee

\_\_\_\_\_  
Signature of Employee

STATE OF NEW YORK    )  
  ) ss.:  
COUNTY OF \_\_\_\_\_ )

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me personally appeared \_\_\_\_\_, to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed the same.

\_\_\_\_\_  
Notary Public

**NOTE: Any fees for medical records are the patient's responsibility.**

**This form must be forwarded to your physician.**



**No-Charge Workers'  
Compensation Time Request  
(BOCES Educators of Eastern  
Suffolk/Paraeducators/Sign  
Language Interpreters)**

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

A BOCES Educator/Paraeducator/Sign Language Interpreter injured as a result of actions by an Eastern Suffolk BOCES student or Eastern Suffolk BOCES parent shall not be charged any accumulated sick days which may be needed as a result of such actions for a period of up to one (1) year. **For additional information, see No-Charge Workers' Compensation Guidelines.** If you feel you may be eligible for no-charge compensation, complete this form.

I. Name _____	Position _____
Work Location _____	Date of Report ____ / ____ / 20____

II. Date of Injury ____ / ____ / 20____	Time of Injury _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
Description of Events Leading to Injury _____ _____ _____	
Other Employees Present/Involved (if applicable) _____	
Other Students Present/Involved (if applicable) _____	

III. Medical Attention Sought
At Work _____
Private Physician (Please attach documentation of treatment.)
Name _____
Address _____
Telephone _____
<b>Please complete Forms 5320F.2 (<i>Medical Records Release</i>) and 5320F.4 (<i>No-Charge Workers' Compensation Medical Information Request</i>) and forward to your physician.</b>

**IV. Submit completed Form 5320F.3 to the Department of Human Resources within 5 business days of injury.**

<b>FOR COMMITTEE USE ONLY</b>	
<input type="checkbox"/> Approval	<input type="checkbox"/> Disapproval _____
Authorized Signature	
You will be notified in writing of the committee's decision.	





**No-Charge Workers' Compensation Medical Information Request**

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

Dear Employee:

Re: Injury Which Occurred on \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_ (to be provided by employee)

The Department of Human Resources requires the information listed below from your physician. For your convenience, you may deliver this letter to your physician for completion.

- Date of Examination: \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_
- Date of Injury: \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_
- Diagnosis:

Documentation Attached:  Yes  No

- Prognosis:

Documentation Attached:  Yes  No

- Any additional relevant information (attach as needed)

**Medical documentation must be submitted to the Department of Human Resources within 10 business days of your injury pursuant to the No-Charge Workers' Compensation Guidelines.**

Thank you for your cooperation in this matter.

DEPARTMENT OF HUMAN RESOURCES