LAWRENCE
PUBLIC SCHOOLS

ACCIDENT REPORTING PROCEDURE

1. Employee must notify supervisor immediately.

2. Employee must complete Sections 1, 3 & 4 on the Accident Reporting Form from Future Comp.

3. Supervisor will investigate accident and insure that the employee takes the appropriate action indicated in this procedure.

4. Supervisor must complete Workers' Compensation form 1B (Responsibility Center Administrators' Report of Employee's Injury) immediately following accident of employee. This **ORIGINAL** Form 1B report should be attached to the **ORIGINAL** Accident Reporting Form and submitted to the Office of Human Resources within 24 hours of the injury.

5. Supervisors must email/fax notification of accident to the Office of Human Resources in case of a serious injury when first report on injury cannot be completed immediately by the employee.

6. If immediate medical attention or treatment is required due to a life threatening injury, call 911 and/or report to Lawrence General Hospital Emergency Room or the Holy Family Hospital Emergency Room. Reports from the hospital emergency room should be submitted within 48 hours to the Office of Human Resources.

7. Non traumatic injuries must to be evaluated immediately at **Pentucket Medical Associates-ExpressCare, 360 Merrimack Street, Building 5, Entry F, Lawrence, MA 01843, Tel. No. (978) 557-8865** before close of business the day of the incident. Pentucket Medical Assoc. must be notified when employee is being sent by Supervisor.

8. Please be advised that emergency medical treatment does not include Physical Therapists, Occupational Therapists, Chiropractors, or other Rehabilitation Therapists. Any injured employee seeking medical treatment other than emergency treatment must first be cleared for treatment through the School Department Utilization Review Agent. Code of Massachusetts Regulations mandates that medical treatment for work related injuries is subject to Utilization review. **All reports of injury must be sent directly to the Office of Human Resources to document, log and forward to our agent for determination if Utilization Review is appropriate and necessary.**

9. Supervisors must conduct a complete investigation of the alleged work related injury, documenting any witnesses and their account of the incident. The supervisor should also forward any other pertinent information regarding an injury, along with a memo accepting or denying responsibility at their level.

10. Attending Nurse will fill out SOAP Notes

If you have any questions or need assistance regarding this procedure, please do not hesitate to contact:

Human Resources Workers Compensation Incident Reporting

(978) 975-5905 ext 25637
Fax (978)722-8544
email –Sonia.Garica@lawrence.k12.ma.us

FutureComp®

ACCIDENT REPORTING FORM

PLEASE PRINT OR TYPE:

EMPLOYEE

1. Employee Name (Last, First, MI)		**2. Home Telephone**	**3. Social Security Number:**
4. Home Address (No & Street, City, State Zip Code)		**5. Marital Status** ☐ **Single** ☐ **Married**	**6. No. of Dependents:**
7. Date of Hire :	**8. Date of Birth:**	**9. Sex** ☐ **Male** ☐ **Female**	**10. Avg. 52-Week: $** ☐ **Estimated** ☐ **Actuarial**

EMPLOYER

11 Employer Name: City of Lawrence-Lawrence Public Schools		**12. Employer Self-Insured** ☑ Yes ☐ No	**13. Federal Tax ID** 04-6001394
14. Employer Address (No & Street, City, State Zip Code): 237 Essex Street Lawrence, MA 01841		**15. Employer Telephone** (978) 975 - 5905	**16. Industry Code**
17. Insurance Carrier or TPA: FutureComp			
18. Workers' Compensation Policy Number:		**19. Business Type:** Education	

INJURY INFORMATION

20. Date of Injury):	**21. Time of Injury** ☐ A.M. ☐ P.M.	**22. Source of Injury (e.g., Machine, Tool, Substance, etc.):**	
23. Address Where Injury Occurred (if different from #18 above):		**24. On Employer's Premises:** ☐ Yes ☐ No	**25. Witnesses:**
26. Regular Occupation:		**27. Regular Occupation When Injured?** ☐ **Yes** ☐ **No**	
28. To Whom Was Injury Reported:		**29. Date Reported:**	**30. Date Reported as Work Related:**
31. Nature of Injury(ies) (Burn, Fracture, Cut, etc.):			
32. Injured Body Part(s) Description (Arm, Leg, Back, etc.):			
33. First Day of Total or Partial Incapacity:		**34. Fifth Day of Total or Partial Incapacity:**	
35. Hospital or Physician Name and Address:			
36. Describe How Injury Occurred (e.g. Struck by……., Fell from……., Exposed to…….):			
37. If Employee Has Returned to Work Date of Return):		**38. Returned to Regular Occupation:** ☐ Yes ☐ No	

	39. Preparer's / Employee's Name (Please Print or Type)	**40. Preparer's / Employee's Title:**
	41. Preparer's / Employee's Signature	**42. Date Prepared :**

FutureComp®

FUTURECOMP CONSENT FOR RELEASE OF MEDICAL INFORMATION

Claim Number:

Insured:

Injured Worker:

Date of Injury:

Date of Birth:

I authorize the release of medical information and facts regarding this injury, including reports and records, results, or diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment relating to this injury. This information is to be used for purpose of evaluating and handling my claim for injury as result of an accident on or about date of injury as identified above on this form.

This will also authorize FutureComp Medical Case Manager if assigned to me to have access to all medical records and Utilization Review Records. The Case Manager may discuss pertinent information with professionals involved in my case to share information as appropriate and necessary for coordination of health care services and coordination with employer for return to work. I understand authorization for Case Management purposes is voluntary and not required.

I am willing that a photocopy of this authorization be accepted with the same authority as the original.

_____ _____

Signature of Injured Worker or Authorized Representative Date

Form #1B

CITY OF LAWRENCE
LAWRENCE PUBLIC SCHOOLS

RESPONSIBILITY CENTER ADMINISTRATOR'S INVESTIGATION REPORT OF EMPLOYEE'S INJURY

Name of Location/Building or place where accident occurred:

Name_____

Street _____ City _____ State _____ Zip _____

2. Date of Injury:_____ Hour of day am/pm_____

3. Name of Employee: _____

Address of Employee: _____

Tel. Number:_____

4. Number of hours worked per day: _____ Number of days worked per week:_____

5. Describe **IN DETAIL** how accident happened and what employee was doing when accident occurred. And describe injury, body part(s), indicating left or right as applicable:

_____

_____

6. Did the employee require medical treatment: _____

7. Has injured returned to work? ☐ yes ☐ no If so, date and hour _____

8. Additional comments:

_____

9. If life threatening situation was emergency response called. ☐ Yes ☐ No

Name of Company providing service: _____

R.C.A. DATE OF THIS REPORT: _____

_____
Responsibility Center Administrator's Signature

_____
Title

MUST BE FILLED OUT <u>COMPLETELY</u> BY SUPERVISOR

CITY OF LAWRENCE
LAWRENCE PUBLIC SCHOOLS

REQUIRED ATTENDING NURSE NOTES

NAME OF EMPLOYEE:_____

S _____

O_____

A_____

P_____

_____

SIGNATURE OF ATTENDING NURSE

_____

DATE

MUST BE FILLED OUT COMPLETELY AND SUBMITTED ALONG WITH THE ACCIDENT REPORTING FORM (EMPLOYEE INJURY REPORT)

LAWRENCE
PUBLIC SCHOOLS

PLEASE REFER ALL WORK RELATED INJURIES FOR IMMEDIATE EVALUATION TO:

Pentucket Medical Associates-ExpressCare
360 Merrimack Street, Building 5, Entry F
Lawrence, MA 01843
Telephone No. (978) 557-8865
Before the close of business on the day of the injury

LIFE THREATENING EMERGENCIES
CALL 911