

SECTION 8

Worker's Compensation Claims – Job Related Accidents and Injuries

A. Accident Reporting Procedure

In the event a job related injury occurs the City provides worker's compensation benefits for employees as required by Florida Statute 440. Both the injured employee and their supervisor/department have responsibilities to ensure the claim is promptly reported to Risk Management.

1. Employee – report any injury, regardless of its severity, to your supervisor immediately after it occurs. You will need to provide specific information in order to properly complete the worker's compensation notice of injury report which is required by the State of Florida.

WARNING: Your failure to timely report a job related accident may result in a denial of your claim.

2. Supervisor/Department – upon notification from an employee of a job related injury, the **supervisor must** obtain sufficient information from the employee to complete the state worker's compensation **notice of injury report** (DWC-1) and the **City's Supervisor Report of Injury**.

These reports are to be forwarded to Risk Management within 24 hours. If you do not have the signature of the employee, forward the report without it indicating "unable to sign" on the employee signature line. **DO NOT** hold up submission of these reports to Risk Management because of your inability to get the employee's signature (due to employee being at home, hospital, etc.).

If you disagree with the employee's description of the accident, please attach a cover memo advising Risk Management of additional information that may be relevant to the investigation of the claim.

3. **Penalties for Late Reporting** – as required in FS440, the City must submit the above reference Notice of Injury report to this worker's compensation claim administration within **7 days** after receiving notice from employee. Failure to comply may result in a **\$500 penalty** for each late report as well as fines to the employee of **\$50 plus interest** if benefits are late.

The City Manager has ordered that any penalties, fines or interest assessed by the State against the City will be charged to the budget of the department that submitted the late report.

Samples of the required accident reports follow this section.

B. Medical Treatment Procedures

1. If any injury requires medical treatment, the employee is to obtain a “medical treatment pass” from their supervisor. All employees are to then proceed to the authorized Occupational Health Center. The pass advises them the injury is work related.
2. If you need **emergency treatment** for a serious injury or need treatment when the **Occupational Health Center is closed**, then proceed directly to the nearest Emergency Room for treatment.
3. If you receive emergency room treatment, report to the Occupational Health Center for follow up and directions the next day they are open.
4. Follow the direction of the Occupational Health Center or treating physician regarding:
 - work status and limitations
 - next appointment or referral to an outside specialist
 - you will receive an injury status report
5. Advise your supervisor immediately of your work status.
6. If you are referred by the Occupational Health Center or our claim administrator to an outside physician, they become the authorized primary care physician for your claim. **DO NOT** return to the Occupational Health Center for follow up. The authorized primary care physician will determine your work status, medical treatment and release you to return to work.
7. **DO NOT GO TO YOUR PERSONAL PHYSICIAN FOR TREATMENT OF A WORK RELATED INJURY UNLESS AUTHORIZED TO DO SO BY RISK MANAGEMENT. UNAUTHORIZED MEDICAL TREATMENT WILL BE AT YOUR OWN EXPENSE.**

C. Light Duty Program

The City has a light duty program for employees with job related injuries that have medically documented physical restrictions which prevent them from performing the essential functions of their job. The purpose of this program is to return the injured employee to productive work as soon as medical cleared by their authorized treating physician. This program is not for employees restricted to light duty to non-employment related injuries.

A light duty return to work assignment is a temporary condition. The expectation is that the employee will return to full duty without restrictions.

If an injury results in the authorized treating physician determining that the physical restrictions are permanent, the department will be notified by Risk Management. At that time, the department needs to confer with Human Resources to determine the permanently injured employee's future employment situation.

When an injured employee receives a light duty or restricted return to work release from their authorized physician the following procedures should be followed:

1. Employee obtains light duty release documentation from their authorized treating physician.
2. The employee should report to their regular workplace and provide this documentation to their supervisor.
3. After reviewing the physician's restrictions, the supervisor determines if any light duty work is available in their department.
4. If the department has light duty work available, the employee continues to work within their department with those restrictions, until a full release is obtained.
5. If no productive light duty exists within their regular department, as determined by the supervisor/department and the Human Resources Department, the department head will contact the Human Resources Department to determine if there is appropriate light duty work elsewhere in the City. If the Human Resources Department identifies appropriate light duty work, the department will instruct the employee to report the next working day to the Human Resources Department for their duty assignment.
6. Employees assigned to light duty will normally report to work **Monday through Friday 8:30 AM – 5:00 PM** and be subject to all normal work and regulations. They will receive a light duty assignment within the physical restrictions as determined by their physician.
7. Employees on light duty will continue to report to the light duty site assigned by the Human Resources department until advised by their supervisor that a light duty assignment exists in their department or are released to full duty by their authorized treating physician.
8. Supervisor should confirm, at least weekly, the employee's work status and obtain sign in sheets verifying the employee's daily attendance in the light duty assignment.
9. Employees on a light duty status will remain on their department's regular payroll.
10. If employee's restrictions become permanent as per their authorized treating physician, their department and the Human Resources Department will be advised in writing by Risk Management.

D. Safety Violation/Preventable Injuries

It is every employee's responsibility to perform their duties in a safe manner. If an employee fails to utilize required and provided safety equipment or violates established safety procedure they may be subject to disciplinary action up to and including termination. If the violation causes an injury with lost work time, the employee may also be subject to a loss of worker's compensation benefits. The Safety Committee and or Safety Officer will investigate and determine preventability of work related accidents and injuries as necessary.

MINIMUM MANDATORY CORRECTIVE ACTIONS FOR SAFETY VIOLATIONS OR PREVENTABLE INJURIES.

These guidelines reflect the **MINIMUM** corrective action to be taken for safety violations or preventable injuries. Safety violations or preventable injuries will follow progressive corrective actions within the guidelines. If an offense occurs within twelve **(12) months** of a previous offense, then the next step in progressive corrective action may be taken. If more than twelve **(12) months** have elapsed since an offense, then the previous offense will be used to support the next step in corrective action.

Any combination of five **(5) PREVENTABLE** offense within twelve **(12) months** may be cause for termination.

All safety violations and injuries will be judged by the Safety Committee and the Safety Officer for preventability.

Violation of safety rules by inspection, review or determination will result in the following:

Progressive discipline:

- 1. First offense a written documentation verbal warning.**
- 2. Second offense a written documented warning.**
- 3. Third offense a one day documented suspension.**

Exceptions to the progressive discipline procedure are:

1. Any violation involving the failure of an employee to utilize provided safety clothing or equipment shall result in the **immediate suspension** of the employee by the division without pay.
2. A preventable or at fault accident which results in bodily injury or property damage shall result in a **3 day mandatory suspension**.

Supplemental disability benefits may be denied where the employee is injured and loses time from work due to a preventable accident or in any instance where the employee was not wearing a seat belt.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPT. OF LABOR & EMPLOYMENT SECURITY
 DIVISION OF WORKERS' COMPENSATION
 For assistance call 1-800-342-1741
 or contact your local EAO Office
 Report all deaths within 24 hours 1-800-219-8953

RECEIVED BY CARRIER	SENT TO DIVISION	DIVISION REC'D DATE

PLEASE PRINT OR TYPE

NAME (First, Middle, Last)		Social Security Number		Date of Accident (Month/Day/Year)	Time of Accident
HOME ADDRESS		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)			
Street/Apt. #:		<input type="checkbox"/> AM <input type="checkbox"/> PM			
City: State: Zip:					
TELEPHONE Area Code Number					
OCCUPATION		INJURY/ILLNESS THAT OCCURRED		PART OF BODY AFFECTED	
DATE OF BIRTH		SEX			
		<input type="checkbox"/> M <input type="checkbox"/> F			

COMPANY NAME:		FEDERAL I.D. NUMBER (FEIN)		DATE FIRST REPORTED (Month/Day/Year)	
D.B.A.:		NATURE OF BUSINESS		POLICY/MEMBER NUMBER	
Street:		DATE EMPLOYED		PAID FOR DATE OF INJURY	
City: State: Zip:				<input type="checkbox"/> YES <input type="checkbox"/> NO	
TELEPHONE Area Code Number		LAST DATE EMPLOYEE WORKED		WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES	
EMPLOYER'S LOCATION ADDRESS (If different)		RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO		LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP	
Street:		IF YES, GIVE DATE			
City: State: Zip:		DATE OF DEATH (If applicable)		RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK	
LOCATION # (If applicable)		AGREE WITH DESCRIPTION OF ACCIDENT?		\$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO	
PLACE OF ACCIDENT (Street, City, State, Zip)		<input type="checkbox"/> YES <input type="checkbox"/> NO		Number of hours per day _____	
Street:				Number of hours per week _____	
City: State: Zip:				Number of days per week _____	
COUNTY OF ACCIDENT:				NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL	
<p>Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree. I have reviewed, understand and acknowledge the above statement.</p>					
EMPLOYEE SIGNATURE (If available to sign)		DATE			
EMPLOYER SIGNATURE		DATE		AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO	

CARRIER INFORMATION

1. Case Denied - DWC-12, Notice of Denial Attached

2. Medical Only which became Lost Time Case (Complete all info in #3)

3. Lost Time Case - 1st day of disability _____/_____/_____ Salary continued in lieu of comp? YES Salary End Date _____/_____/_____
 Date First Payment Mailed _____/_____/_____ AWW _____ Comp Rate _____
 T.T. T.T.-80% T.P. I.B. P.T. Death

REMARKS: _____

CARRIER CODE #			EMPLOYEE'S RISK CLASS CODE			EMPLOYER'S SIC CODE		
SERVICE CO/TPA CODE #			CARRIER FILE #			CARRIER NAME, ADDRESS & TELEPHONE		
						Johns Eastern Company, Inc. Post Office Box 3318 Sarasota, FL 34230 (941) 907-3100 • (800) 749-3044		
						Is employer self-insured? <input type="checkbox"/> YES <input type="checkbox"/> NO		

LES Form DWC-1 (11/94)

Reorder MBF 407-657-7414

**CITY OF MIAMI BEACH
SUPERVISOR'S REPORT OF ACCIDENT**

Employee Information

Name of Employee: _____	
Dept/Div: _____	Years of Service: _____
Age: _____	Position: _____

Accident Information

Date: _____	Time: _____	Place: _____
Accident first reported to: _____		
Witnesses: _____		
Describe how accident occurred: _____ _____		
Type of Injury: _____	Part of Body: _____	
Medical Treatment by: _____		
Losing time from work due to injury?	___ Yes	___ No
Cause of Accident (Check Any That Apply):		
<input type="checkbox"/> Inadequate Supervision	<input type="checkbox"/> Carelessness	
<input type="checkbox"/> Improper/Inadequate Instructions	<input type="checkbox"/> Poor Judgement	
<input type="checkbox"/> Failed to follow orders	<input type="checkbox"/> Failure to use safety equipment	
<input type="checkbox"/> Unsuitable for position	<input type="checkbox"/> Dangerous condition	
<input type="checkbox"/> Poor work attitude	<input type="checkbox"/> Defective equipment	
<input type="checkbox"/> Caused by another party (explain): _____		
<input type="checkbox"/> Other (explain): _____		
Action taken to prevent similar accident (Check Any That Apply):		
<input type="checkbox"/> Instructed Employee	<input type="checkbox"/> Replaced/repared equipment	
<input type="checkbox"/> Training	<input type="checkbox"/> Change of job duties	
<input type="checkbox"/> Corrected hazard/condition	<input type="checkbox"/> Other (explain) _____	

Has this employee had similar accidents?	___ Yes	___ No
Explain: _____		

Date	Signature	Position
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Complete this form for any accident involving an employee, and return to Risk Management. In case of an emergency, contact us at 673-7014, or fax: 673-7023

POLICY: To provide guidelines for the utilization of light duty work.

DEFINITION(S):

Light Duty status means that an employee injured on the job can return to work, provided his/her workers' compensation physician has authorized the employee to return to work and perform certain duties based on his/her condition.

PROCEDURES:

- ◆ The workers' compensation physician authorized an assignment to light duty status.
- ◆ The assignment will be for a temporary period. After this period, the employee will return to full duty.
- ◆ The employee reports to his/her regular workplace, with documentation of his/her release and specific restrictions from the physician.
- ◆ After reviewing above restrictions, the employee's supervisor determines whether there is any productive light duty assignment(s) available.
- ◆ If light duty work is available in the employee's department, he/she is assigned and continues to report to that location during the length of the assignment(s) or until the light duty status ends.
- ◆ When light duty status ends the employee returns to full duty at his/her department with the written approval of the physician. Written approval for a full duty release must be provided by the physician and presented to the employee's supervisor upon return to work.
- ◆ Light duty jobs are not an entitlement. Such assignment will be made only when the employee can perform necessary work in a productive manner as judged by the Department Director.

NOTE:

During the light duty period, employees will continue to be treated by the workers' compensation physician. Employees will be excused to attend required doctor visits related to their injury without using their leave time.

Light duty assignments are temporary assignment only. If the employee's disability becomes permanent, Risk Management will notify his/her department and the Human Resources Department.

WARINING:

While on light duty, assignment attendance will be taken and the employee's department will be notified of absences, tardiness, etc. for payroll purposes. Failure to report to the Light Duty Program without following the appropriate City work procedures will result in a charge of Absence Without Leave Without Permission (A WOL).

REFERENCE: