



School District of Indian River County

6500 57th Street • Vero Beach, Florida, 32967 • Telephone: 772-564-3000 • Fax: 772-564-3054

David K. Moore, Ed.D. - Superintendent

How to file a Workers' Compensation claim and obtain medical assistance.

In the event of life-threatening injury or illness – call 911.

All work-related injuries or illnesses must be reported as soon as possible and no later than 24 hours after the incident or fines and penalties may be imposed by the state and the claim may be denied.

1. Report non-emergency injuries during normal work hours by calling **772-564-3130**.
 - a. Report after normal work hour non-emergency injuries by calling **772-217-9466**.
2. Complete the "First Report of Injury or Illness Form" *before* obtaining treatment.
3. Complete the "Medical Care Acknowledgement Statement Form" *before* obtaining treatment.
4. Complete the "Occupational Safety Report" form *before* obtaining treatment.
5. Forms are available on the District web site at: <https://www.indianriverschools.org/risk-management>.
6. Email completed forms to the Workers' Comp office at: Dist.CO.WorkersCompClaims@indianriverschools.org to receive treatment authorization.
7. **Treatment must be authorized in advance by the Workers' Compensation (WC) office.** The WC office will provide the employee with an authorization form to take to the WC authorized physician.
8. WC has its own **Prescription** plan. Do not use the SDIRC prescription plan. The WC office will provide a WC authorization letter for prescriptions. Call the WC office to obtain the form.
9. Additional medical services: The WC Office must authorize additional medical services before appointments can be scheduled and or services provided. Unauthorized treatment will not meet WC standards nor be reimbursed. Call the WC office to obtain the necessary authorization.
10. The employee is required to report back to work following all WC treatment or to call the WC office regarding their work status if they are unable to report back to work.
11. All authorized WC appointments will be excused absences. Every effort will be made to schedule appointments at the beginning or end of the workday to avoid disrupting the work schedule.

Please call the Workers' Compensation Office anytime you have questions. We can be reached at 772-564-3130 or 772-564-3129. Thank you – safety matters.

Dr. Mara Schiff
District 1

• Jacqueline Rosario
District 2

• Dr. Peggy Jones
District 3

• Teri L. Barenborg
District 4

• Brian M. Barefoot
District 5

FIRST REPORT OF INJURY OR ILLNESS
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
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 or (850) 922-8953

RECEIVED BY CLAIM-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

Name (First, Middle, Last)		Social Security Number	Date of Accident	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
Home Address Street/Apt. #: _____ City: _____ State: <u>FL</u> Zip: _____		Employee's Description of Accident (Include Cause of Injury)		
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			

EMPLOYER INFORMATION

Co. Name: <u>School District of Indian River Co.</u>	Federal ID Number (FEIN) <u>59-6000673</u>	Date First Reported (Month/Day/Year)
D.B.A.: _____	Nature of Business Education	Policy/Member Number
Street: <u>6500 57th Street</u>	Date Employed	Paid for Date of Injury <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State Zip: <u>Vero Beach FL 32967</u>	Last Date Employee Worked	Will you continue to pay wages instead of Workers' Comp? <input type="checkbox"/> Yes
Telephone: (Area Code) _____ Number _____	Returned to Work <input type="checkbox"/> No If Yes, Give Date <input type="checkbox"/> Yes	Last day wages will be paid _____
Employer's Location Address (if different) Street: _____ City/State/Zip: _____ FL _____ Location # _____	Date of Death (if applicable)	Rate of Pay \$ _____ Per <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> DAY <input type="checkbox"/> MO
Place of Accident (street, city, state, zip) School/Depart: _____ Street: _____ City/State/Zip: _____ County of Accident: _____	Agree with description of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of hours per day _____ Number of hours per week _____ Number of days per week _____
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 commits insurance fraud, punishable as provided in Florida Statute 817.234, Section 440.105(7), F.S.		Name, Address Telephone and Fax of Physician or Hospital CareHere 5525 41st Street Vero Beach, Florida 32967 Phone: (772) 617-2300
Employer Signature (if available)	Date	Call 911 or go to the nearest Emergency Room for life threatening injuries or illnesses.
Employee Signature (if available)	Date	Authorized by Employer <input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIMS-HANDLING ENTITY INFORMATION

1a <input type="checkbox"/> Case Denied - DWC-12, Notice of Denial Attached	2 <input type="checkbox"/> Medical Only which became Lost Time Case (Complete all info in #3)
1b <input type="checkbox"/> Indemnity Only Denied Case - DWC-12, Notice of Denial Attached	Employee's 8th Day of Disability ____/____/____
3. <input type="checkbox"/> Lost Time Case -- 1st day of disability ____/____/____	Entity's Knowledge of 8th Day of Disability ____/____/____
Full Salary in lieu of comp? <input type="checkbox"/> YES	Full Salary End Date _____
Date First Payment Mailed ____/____/____	AWW _____
Comp Rate _____	
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T.-80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> Death <input type="checkbox"/> Settlement Only	
Penalty Amount Paid in 1st Payment \$ _____	Interest Amount Paid in 1st Payment \$ _____

Remarks:		Insurer Name: School District of Indian River County
		Claims-Handling Entity Name, Address & Telephone
INSURER CODE # <u>9288</u>	Employee's Class Code (Select Class Code) <u> </u>	Relation Insurance & Benefits Solutions, Inc
Service Co/TPA Code # <u>6060</u>	Employer's NAICS Code <u>611110</u>	700 Central Parkway
	Claims-Handling Entity File #	Stuart, FL 34994
		1-800-431-2221



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2021 Risk Management Medical Care Acknowledgement Statement

DWC-1 Purpose and Use Statement: The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier by the Division of Workers' Compensation database for individuals who have claimed benefits under Chapter 440, FS. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits for internal agency tracking purposes and for purposes of responding to both public records request and subpoenas that require production of specified documents under the law. Your social security number may also be used for any other purpose specifically required as authorized by state or federal law. **Authorization to Furnish Medical/Employment Information:** In order to assist with the handling of my claim with Relation Insurance Services, I authorize my employers and all persons with knowledge of my injuries to furnish employment and medical information to Relation. My understanding of this authorization is as follows: **Information to Be Released:** Relation may request all information related to my claim, including information related to diagnosis, treatment records and bills, medical histories, assessments of past, current and expected physical condition as well as current and historical employment, wage and benefit information. Relation may either review or photocopy this information. **Sources of Information:** Relation may contact the appropriate medical providers, insurance companies, and employers and provide them with a copy of this authorization in order to obtain the necessary information. **Use of Provided Information:** Relation and its representatives (such as medical providers or lawyers) retained by Relation will use this information to verify and evaluate my claim in order to determine any appropriate resolution. Relation may also release the information to professional organizations whose purpose is to detect insurance fraud, and may release it to other insurance companies to whom a claim has been or may be submitted. **Time Period of this Authorization:** I understand that this authorization will remain valid until my claim with Relation is legally concluded. I also understand that I can revoke this authorization at any time by notifying Relation in writing. **Copies of this Authorization:** I can request a copy of this signed authorization at any time from Relation.

Medical Care Acknowledgement Statement: (Please circle one) **I DO or DO NOT wish to seek medical attention at this time.** Medical care is available at the preauthorized provider as identified on the front of the First Notice of Injury form (DWC-1). Should I need medical attention at a later date, concerning this incident, I understand that it is available up to two years from the date of the injury and that I will notify my immediate supervisor and the Risk Management Department. All treatment must be preauthorized. **THIS IS NOT A RELEASE OF MY CLAIM. I UNDERSTAND THAT SIGNING THIS FORM DOES NOT MEAN I HAVE SETTLED MY CLAIM. ALL RIGHTS AND RESPONSIBLTIES REMAIN IN EFFECT.** Please call the Risk Management Department at 772-564-3129 if you should need additional information.

_____	_____	_____
Print Name	Date	Signature
_____	_____	_____
Witness Name	Date	Signature



Purpose: To ensure that occupational safety and hazard policies and procedures are properly in place and to correct those that are not.

Objective: All accidents are investigated, recorded and promptly reported. Each workplace injury or illness shall be documented on this form.

Instructions: Please write legibly. The injured worker shall complete section A and section E of this report and attach it to the First Notice of Injury Report. Both forms shall be submitted to the supervisor *before obtaining treatment*. *TREATMENT must be preauthorized by Risk Management except for life-threatening emergencies*. The injured worker's supervisor shall complete section B and submit both forms to the School Principal or Department Administrator who in turn shall complete Section C and submit both forms to Risk Management for treatment authorization. Risk Management will forward the forms to the Assistant Superintendent or Superintendent for completion of section D and compile the data to report back to all parties.

SECTION A. INJURED WORKER

1.Name		2.School/Dept:	
3.Date of accident: MM/DD/YYYY Time: AM PM		4.Job Title	
6.Specific location of accident:		5.Address of Accident	
		City	State
7.What were you doing at the time of the accident?			
8.What were you doing just before the accident?			

9. Describe the accident. On the lines below carefully tell what happened in your own words. Please make sure to write a statement to answer the questions: Who? What? When? Where? How and or Why did it happen. Use the back of this report if you need more room.

10. Did the accident/incident involve a traffic report or a police report?
If so, please provide a copy of the report or report number. If SDIRC Vehicle provide Unit ID# and accident report.

11. Were there witnesses? Name: Title: Phone Number:

12. More than one witness? Name: Title: Phone Number:

13. What do you recommend could have been done to prevent this accident from occurring?

14. Employee Signature: Date: Phone Number:

SECTION B. INJURED WORKER SUPERVISOR

15. Supervisor's Name Title: Phone Number:

16. Was the area secured? Yes No Not Necessary 17. Specify location:

18. Pictures/Video documented sent to Maintenance/Facilities/Risk? 19. Sketch Accident Scene below

20. What was the root cause of the accident? Develop a Corrective Action Plan below and be specific to root cause of accident.

21. What will be done to prevent reoccurrence?	22. When will the corrective action be completed? (date)	23. Who is responsible for getting it done?

Supervisor Signature: Supervisor Print Name: Date:

SECTION C. SCHOOL PRINCIPAL/DEPARTMENT DIRECTOR

24. Principal/Department Director Name: Phone Number:

25. Do you agree with the above findings? Why or Why not?

26. When will you follow-up to ensure compliance with the corrective action plan? What date?

School Principal/Department Director Signature: Date:

SECTION D. ASSISTANT SUPERINTENDENT/SUPERINTENDENT

27. Assistant Superintendent/Superintendent Phone Number:

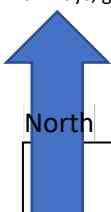
28. Do you agree with the above findings? Why or Why not?

29. Were all the Correction Action Plans completed? Additional recommendations?

30. Assistant Superintendent/Superintendent Signature: Date:

SECTION E. ACCIDENT ILLUSTRATION

Sketch accident scene here. Draw a diagram to illustrate the scene of the accident, note the location of equipment, fixed objects, desks, chairs windows, doors, walkways, gates, personnel, vehicles and landmarks. Note anything you think may be significant. Use the back of this report if you need more room.



Email your completed section of this report to: RiskManagementincidents@indianriverschoos.org.
Thank you - Safety matters!