

Category: 7000 PERSONNEL	Policy Number: 7390
Policy Title: Workmen's Compensation	Effective Date: August 18, 2010

All employees of Snake River School District 52 are covered by Workmen's Compensation insurance for bodily injury, disease, or death caused by an accident arising out of and in the course of their employment. The District is required by law to carry Workmen's Compensation with the State Insurance Fund. Premiums are paid by the District.

Any person who knowingly, and with intent to defraud or deceive, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

It shall be the Board's policy to provide a return to work program after a work-related injury to facilitate the earliest possible return of injured workers to the workplace to perform meaningful, productive work within their physical capabilities. The Transitional (or Alternative Duty) Work Program is mandatory for all exempt and non-exempt employees who have been released by the healthcare provider to some form of restricted-duty work. The Transitional Work is intended to be time-limited and temporary.

A Transitional Work Program benefits employees in several ways:

- Increases their self-esteem, minimizing feelings of guilt for having been injured;
- Promotes better morale among all workers;
- Contributes to faster recovery by keeping the injured worker mentally and physically conditioned to the regular work schedule;
- Maintains social contact with fellow employees, which enhances recovery and encourages a faster return to the job;
- Reduces the negative financial impact many injured workers experience due to lost time.

Legal References: Idaho Code 72-901-72-929
Idaho Code 72-801
Idaho Code 330-1271 (c)

Reference: Policy 7650, "Family and Medical Leave"
Procedure: 7390p, Workman's Compensation
Form 7390f, "Employee Workman's Compensation Signature Page"
Form: "Employee and Supervisor Accident Report"
Form: "Workers Compensation - First Report of Injury or Illness"
Form: "Mountain View Hospital Occupational Health Solutions Injury/Illness Form"

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District's Responsibility to Report Possible Workmen's Compensation Claims:

All employees of the Snake River School District 52 are covered by Workmen's Compensation Insurance for bodily injury, disease, or death caused by an accident arising out of and in the course of their employment.

The District Office must report every work injury which requires medical services, other than first-aid treatment, to the appropriate authorities within ten (10) days after being notified of the injury.

Any person who knowingly, and with intent to defraud or deceive, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. (Idaho Code 72-801).

Disability Pay

Whenever an employee is injured on the job and makes a claim for disability pay through the State Insurance Fund (Workman's Compensation), and receives such pay, the district will supplement the difference between what the employee receives from Workman's Compensation and his or her regular monthly wages. The employee's accumulated sick leave will be charged only for the district's supplement of the employee's full wage. Sick leave charged will be calculated based on the employee's current daily pay rate. Time for which a person is paid workmen's compensation shall not be allowed as sick leave. If the employee has no accumulated sick leave, there will be no deficiency supplementation from the district.

An employee who is on an extended work compensation leave is considered to be on Family and Medical Leave Act leave concurrently. In compliance with The Family and Medical Leave Act, the district will continue the benefit portion of health, dental, and life insurance for a period of three months from the first date of disability. The employee is responsible to pay the deduction portion of these insurance premiums to continue coverage. If the deduction is not paid by the 5th of the month, coverage will be terminated.

Employees must submit a progress report from their physician after each doctor appointment.

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Employee responsibility when a work-related injury or illness occurs:

1. The employee must report the incident to the supervisor immediately. (Regardless of how insignificant you feel it may be.)
2. At the time of the accident, the employee and supervisor will determine the severity of the injury. A determination will be made to do one of the following:
 - Remain at work to continue the shift;
 - Seek medical attention through a care provider of our choice;
 - Seek medical attention through an emergency care provider for severe or life threatening injuries.
3. Post-injury drug testing will be mandatory.
4. In order for the work-related injury to be compensable, the employee **MUST** be evaluated by the District's Medical Provider within 24 hours of the accident or as the medical condition permits. If the injury did not require a doctor's visit at the time of the accident but has progressed to the point of needing medical attention, the employee must also be evaluated by the District's Medical Provider either in place of or within 24 hours of receiving medical care.
5. After evaluation and treatment by our Medical Provider, the employee must return to work with the paperwork from the doctor. If, for medical reasons, the employee is unable to return to work immediately, the employee must notify the supervisor and provide documentation as to medical status.
6. The employee is required to obtain a return to work form from the physician and present it to his/her supervisor upon returning to work. The supervisor will then send the form to the District Office.
7. If any restrictions are recommended, the employee is responsible for following these restrictions both on and off the job. Failure to do so will result in disciplinary action up to and including termination.
8. The employee will be responsible for notifying his/her supervisor of all medical appointments.
9. The District will make an effort to provide meaningful, productive work within an injured worker's physical capabilities as prescribed by the treating physician.

MEDICAL PROVIDER LIST FOR SNAKE RIVER SCHOOL DISTRICT #52:

**Blackfoot Medical Clinic
1441 Parkway, Blackfoot
785-2600**

**Mountain View Hospital
RediCare (Westside) 919 S. Utah, Idaho Falls
542-7000**

**Emergency (except life-threatening) (24 hour service)
Mountain View Hospital
RediCare (Eastside) 2730 Channing Way, Idaho Falls
542-7100**

Costs for treatment by another medical provider may be denied by the District's Workers' Compensation carrier and become the responsibility of the injured employee.

Category: 7000 PERSONNEL	Procedure or Form Number: 7390f
Policy Title: Employee Workman's Compensation Signature Page	Effective Date: August 18, 2010

Purpose:
To give you necessary information regarding your workers' compensation claim.

Procedure:

There are basic rules that apply to your worker's compensation claim.

- **You are responsible for having a medical evaluation by the District's Medical Provider within 24 hours of any time-loss work-related injury.**
- **You will be required to pass a drug screen for your claim to be approved.**
- **The District will make an effort to provide meaningful, productive work within any physical restrictions prescribed by the treating physician.**
- **If it is necessary for you to receive off-site treatment for a work-related injury, you must notify your supervisor prior to the appointment time.**
- **Notify your supervisor of all follow-up appointments with the physician and/or physical therapist.**
- **Make sure that your supervisor is aware of any medications that have been prescribed for you.**
- **Bring all paperwork to the District Office following each appointment with the physician.**
- **Make sure that your supervisor is aware of any medical restrictions authorized by the physician.**
- **If you are given any work restrictions, you must follow them both on and off the job.**
- **In the event that your claim is denied by the workers' compensation carrier, you will be responsible for payment of any of the medical expenses.**
- **An employee who is on an extended work compensation leave is considered to be on Family and Medical Leave Act leave concurrently. In compliance with The Family and Medical Leave Act, the district will continue the benefit portion of health, dental, and life insurance for a period of three months from the first date of disability. The employee is responsible to pay the deduction portion of these insurance premiums to continue coverage. If the deduction is not paid by the 5th of the month, coverage will be terminated.**

I have been given the opportunity to read the above information regarding my workers' compensation claim rights. My signature indicates that I understand those rights and responsibilities.

Employee Signature

Date

Employee's Printed Name

MOUNTAIN VIEW HOSPITAL OCCUPATIONAL HEALTH SOLUTIONS

Initial Employee Injury/Illness Treatment Form

7390F2

Please Mark Treating Facility

- | | |
|--|--|
| <input type="checkbox"/> RediCare – 919 S.Utah, Idaho Falls, ID 83402
<input type="checkbox"/> RediCare – 2730 Channing Way, Idaho Falls, ID 83404
<input type="checkbox"/> Community Family Clinic 2088 E. 25 th , Idaho Falls, ID 83404
<input type="checkbox"/> Blackfoot Medical Clinic, 1441 Parkway, Blackfoot, ID 83221 | <input type="checkbox"/> Shelley Medical Clinic 210 S. Emerson, Shelley, ID 893274
<input type="checkbox"/> Firth Medical Clinic 114 S. Main, Firth, ID 83236
<input type="checkbox"/> Upper Valley Family Medicine, 530 Rigby Lake Dr., Rigby, ID 83442
<input type="checkbox"/> Rexburg Medical Center, 393 E. 2 nd N., Rexburg, ID 83440
<input type="checkbox"/> Intermountain Medical Center 1951 Bench Rd., Pocatello, ID 83201 |
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Employee Name		SSN	Date of Birth	Date
Job Title		Department		Home Phone
Hire Date	Hours per Day	Hours per Week	Incident Report Completed Yes No	
Location Where Injury Occurred		Date of Injury	Time of Injury am / pm	Date Injury Reported Time Injury Reported am / pm
Name of Witnesses		Supervisor/Manager		

Please Describe Occurrence (Be specific & Include Exact Body Part)

Employer Information

Employer Name (Business Name) Snake River School District #52	Employer Address 103 South 900 West, Blackfoot, ID 83221	Employer Phone Number: 684-3001 Fax Number: 684-3003
Employer Workers' Compensation Contact State Insurance Fund	Workers' Comp Insurance Company Policy Number: 279820	

Employee Medical Release

I hereby authorize this facility (or any of its representatives) to be furnished any information and facts regarding this injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the purpose of evaluating and handling my claim for injury as a result of an occurrence on or about the above-mentioned date, and for no other purpose, now or in the future. A photostatic or other copy of this release, which contains my signature shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for.

Employee Signature _____ **Date** _____

Medical Provider Assessment And Treatment

Diagnosis	Aggravation of Pre-Existing Condition? Yes No
Treatment Administered	
Labs	X-Ray Prescription

Patient Disposition
 Return to Supervisor _____ Admitted to Hospital _____
 Return to Supervisor, Send home until _____ Return to Supervisor with restrictions (Complete Physical Restrictions Section Below)

Physical Restrictions

Limit Lifting/Carrying To:	Limited Pushing/Pulling To:	No Pushing/Pulling
0-5 lbs 11-25 lbs No lifting/carrying	0-5 lbs 11-25 lbs	Other: _____
6-10 lbs. 26-50 lbs Other: _____	6-10 lbs 26-50 lbs	

No Exposure to Vibrating Tools No Climbing No reaching above shoulders Other: _____
 No Operation of Moving Machinery No reaching below waist No use of RIGHT / LEFT Hand _____

Time Limitations
 Work Requiring repeated stooping, crawling, kneeling, or being in a cramped position limited to _____ min/hr.
 Continuous Walking Limited to _____ minutes/hour Repetitive Hand/Wrist motion limited to _____ minutes per hour
 Continuous Standing Limited to _____ minutes/hour Work Day limited to _____ Hours per Day
 Continuous Sitting Limited to _____ minutes/hour

Duration of Physical Restrictions:

Medical Provider Signature	Date	Referred To	Follow- up Appointment
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Disposition of Employee

Employee Cannot be accommodated at this time Was Sent Home per Physical Instructions	Return to full duty – No restrictions Employee has been placed in an appropriate Transitional Duty Position	Refused Transitional Duty
Supervisor/Manager Signature	Date	Injury Coordinator Signature Date

