Workers' Compensation Acknowledgment Form

Workers' Compensation provides benefits to employees who sustain a work-related injury that arise during the course of your employment. Refer to the Richmond County School System Employee Handbook for additional details regarding Workers Compensation.

PROCEDURE:

1. You must report all accident to us immediately. Your benefits could be delayed or denied if you do not notify us immediately. **When a claim is investigated and determined not compensable, you may be responsible for any bills that are incurred.**

2. Employees who require emergency treatment must obtain prior authorization which is obtained by contacting Workers' Comp Division at 706-826-1305 or 706-826-1000. IF THE INJURY IS NOT LIFE THREATENING, YOU MUST SEEK TREATMENT THROUGH A DOCTOR'S OFFICE (see the Panel of Physicians). EMERGENCY ROOM VISITS ARE NOT CONSIDERED A DOCTOR'S OFFICE VISIT.

3. **NOTE:** Emergency Clinics, the Veteran's Administration Medical Center, Eisenhower Medical Center are **NOT** authorized facilities for Workers' Compensation treatment.

4. If medical attention is needed, select a doctor from the *"Panel of Physicians"* posted at your work location as well as the *"Employee's Bill of Rights".* An authorized school/department representative must call and schedule the initial appointment.

5. Complete the following forms when filing a workers' compensation claim:
   - ✓ **Employee Accident Report**
   - ✓ **Employer Notification for Treatment of a Work Related Injury Form**
   - ✓ **Workers' Compensation Acknowledgement Form**

   Forms can be obtained from the school nurse, school secretary, bookkeeper, principal/director or your work facility and on our website: www.rcboe.org

6. Any absence due to a work-related injury/illness will not count towards an employee's retirement. Workers' Compensation does not pay into retirement entities. Vacation and/or sick time will not accrue during a Workers' Compensation absence.

Any person who, knowingly with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing false or misleading information is guilty of a felony in the third degree.

ACKNOWLEDGMENT

I hereby certify that I was provided with the above statement, and I acknowledge my agreement with my signature below:

Social Security #:	**Date:**
Print Name:	**Signature:**

Revised: 07/2017