SUFFOLK COUNTY WATER AUTHORITY
WORKERS' COMPENSATION

INJURY AND MEDICAL REPORTING PROCEDURE

If you are involved in an on-the-job injury, you must:

- Report the accident to your immediate supervisor **and** to Maria Astuto in HR.
- Complete the attached 24 Hour Accident Report (Form 12) as soon as possible.

If you require medical attention as the result of an on-the-job injury, you must:

- File a 24 Hour Accident Report (Form 12) as required above.
- Seek medical treatment within 72 hours of being injured.
- Advise your physician that your injury is work related **and** provide the insurance information below.
- Have your physician complete the attached *Monthly Medical Report* (Form 12A) addressing your degree of disability **and** outlining your ability to work either full or modified duties.
- All medical documentation must be returned to Maria Astuto in HR as soon as possible.

If your on-the-job injury results in lost time from work, you must:

- File a 24 Hour Accident Report (Form 12) as required above.
- Get examined by a physician and return the attached Monthly Medical Report (Form 12A).
- For continued lost time, a Monthly Medical Report (Form 12A) must be submitted to Maria Astuto in HR **every four weeks** which addresses your degree of disability **and** work ability.

SCWA offers an extensive Return to Work/Modified Duty Program.

When returning to work on light/modified duty, you must:

- Provide a completed SCWA Monthly Medical Report (Form 12A) **prior** to returning to work and every four weeks thereafter. All medical **must include** a specific list of work restrictions.
- If restrictions are not included in the medical report, you will not be permitted to return to work.

For injuries occurring on or after *April 1, 2016*, our *new* Insurance company is:

Sedgwick
PO Box 14545
Lexington, KY 40512-4545
Phone: 631-768-1100
Fax: 631-454-2700

SUFFOLK COUNTY WATER AUTHORITY
WORKERS' COMPENSATION

WC EXCUSED TIME FOR MEDICAL TREATMENT

When utilizing Workers' Compensation "Excused Time" for a medical appointment, therapy session etc., you are required to provide medical documentation substantiating each absence prior to the close of the payroll period.

A "WC Excused Time" request form must be attached to the medical documentation which includes the following:

- Date and time of the appointment.
- Date of injury you are being treated for.
- Diagnosis with notation that the treatment is due to an on-the-job injury.
- The treating physician's signature and office stamp providing their address and phone number.

Failure to provide the necessary request form and medical documentation will result in your accruals being charged.

In accordance with the Collective Bargaining Agreement, Article XV, Section 8:
"The Authority will not permit portions of a day to be charged as Excused Time for medical treatment except if the medical treatment is scheduled during the last two hours of a normal workday and the medical treatment is not available at any other time. In addition, the Authority, upon application to the Human Resources Department, may permit employees to charge portions of a day for medical treatment. Requests shall not be unreasonably denied."

Note: The Authority will permit employees to use excused time to attend Independent Medical Exams (IMEs) as requested by the Authority or its insurance carrier and to attend Workers' Compensation Board hearings as required by NYS.
Excused time as set forth above will be permitted only upon submission of a hearing notice and/or IME appointment letter.

Should you have any questions or concerns, please contact **Maria Astuto in HR**:

Office: 631-563-0392
Fax: 631-563-0300
Email: Maria.Astuto@scwa.com

Accident Investigation Report

General Incidents, Injuries, and Workers Compensation Claims

Employee Information

Employee's Name: | SCWA ID #: | Phone Number:

Supervisor's Name: | Job Title:

Incident Information

Date of Injury: ___/___/___ Time of Injury: ___:___ AM PM | Date Reported: ___/___/___ Time Reported: ___:___ AM PM | Reported to a supervisor within 24 hrs?: ☐ YES Reported to: _____ ☐ NO

Address of the Incident Site:

Street/Building _____ ☐ Outdoors/Yard ☐ Pump Station

City _____ Zip Code _____ ☐ Indoors/Building ☐ Residential/Excavation/Service

Description of the Injury/Incident Severity Characteristics

Body Part Injured: ☐ LEFT ☐ RIGHT

☐ Head ☐ Face ☐ Mouth ☐ Shoulder ☐ Elbow ☐ Hand ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Back:Upper/Mid/Lower

☐ Neck ☐ Eye ☐ Abdomen ☐ Arm ☐ Forearm ☐ Finger(s):_____ ☐ Thigh ☐ Lower Leg ☐ Foot ☐ Toe(s): _____

Injury Type (check all that apply):

☐ Insect Bite ☐ Bruise/Swelling ☐ Cut/Laceration ☐ Burn ☐ Head Injury ☐ Hearing Loss ☐ Electrocution ☐ Internal Damage

☐ Poison Ivy ☐ Sprain/Strain ☐ Dislocation ☐ Fracture ☐ Abrasion/Scrape ☐ Occupational ☐ Other:_____

Injury Cause (check all that apply):

☐ Environmental ☐ Fall from Height ☐ Body Movement ☐ Chemical ☐ Struck by Moving Object ☐ Impact/Body Part Hitting Fixed Object

☐ Slip/Trip/Fall ☐ Sharp Object ☐ Repetitive Motion ☐ Electrical ☐ Noise/Sound ☐ Other:_____

Thoroughly describe how and why the incident happened:

Name(s) of Witness:_____

Are you: ☐ Left-handed ☐ Right-handed | Did you finish your entire shift the day of the incident? ☐ YES ☐ NO

Have your ever been treated for a similar injury or condition? ☐ YES ☐ NO If so, Approx. Date : ___/____

Medical Treatment

Treatment: ☐ NONE ☐ Hospital ☐ Walk-In Clinic ☐ Doctor's Office | Doctor's Name:

Treatment Center Address:

Street_____ City _____ Zip Code _____

Supervisor's Investigation

Was the employee in the scope of his/her regular or assigned job task(s)? ☐ YES ☐ NO (Explain Below)

If no, why?

Contributing Factors (check all that apply):

☐ Inexperience ☐ Unsafe Act ☐ Lifting/Pulling ☐ Defective Equipment ☐ Procedure Not Followed

☐ Improper Tool ☐ No PPE Worn ☐ Heavy Equipment ☐ Lack of Equipment Utilization ☐ No Procedure Exists

☐ Uneven Surface ☐ Ice/Snow ☐ Tall Grass/Wooded ☐ Hand/Powered Tool ☐ No Training Provided

☐ Other:_____

How can we prevent the same incident from happening again?:

ONCE THIS FORM IS SIGNED & COMPLETED - SEND A COPY TO THE ACCIDENT REPORT EMAIL GROUP

Required Signatures

Employee's Signature: _____ Date: ___/___/___

Supervisor's Signature: _____ Date: ___/___/___

Rev A - 1/4/2019

SUFFOLK COUNTY WATER AUTHORITY

REQUEST FOR USE OF EXCUSED WORKERS' COMPENSATION TIME

Name: _____ Employee No: _____

Injury Date: _____

Type of Excused Time Requested: (Circle One)

Doctor's Visit *WCB Hearing* *Independent Medical Exam (IME)*

Date of Requested Excused time: _____ Appointment Time: _____

Leaving work time: _____ Amount of Time Requested: _____ (Maximum 2 hrs)*

Physical Address of Appointment: _____

***In accordance with the Collective Bargaining Agreement, Article XV, Section 8: "The Authority will not permit portions of a day to be charged as excused time for medical treatment except if the medical treatment is scheduled during the last two hours of a normal workday and the treatment is not available at any other time. In addition, the Authority, upon application to the Human Resources Department, may permit employees to charge portions of a day for medical treatment. Requests shall not be unreasonably denied."**

I state that the above information is correct and appropriate documentation is attached.

_____

Employee's Signature and Date

ALL SUPPORTING MEDICAL DOCUMENTATION MUST INCLUDE:

DATE AND TIME OF APPT (PROVIDED ON THE DOCTOR'S LETTERHEAD) AND SIGNED BY A PHYSICIAN.

DATE OF INJURY EMPLOYEE IS BEING TREATED FOR INCLUDING DIAGNOSIS.

IN THE EVENT OF A WORKERS' COMPENSATION BOARD HEARING, THE EMPLOYEE SHOULD ASK THE HEARING CLERK TO TIME AND DATE STAMP OR INITIAL THE HEARING NOTICE UPON THEIR ARRIVAL AND EXIT FROM THE HEARING LOCATION.

IF ACCEPTABLE DOCUMENTATION IS NOT PROVIDED, THE EMPLOYEE'S ACCRUALS WILL BE CHARGED.

PLEASE RETURN THIS FORM TO MARIA ASTUTO IN HUMAN RESOURCES UPON COMPLETION.

OFFICE USE:

DOCTOR'S OFFICE CALLED TO VERIFY APPT/OFFICE HOURS _____ _____

DATE SIGNATURE

Suffolk County Water Authority

Workers Compensation – Employee Medical & Work Status Form

To be Completed by Attending/Treating Physician

MEDICAL RELEASE:
Please accept this as your authorization to provide my employer, Suffolk County Water Authority, with a full medical report on my condition.

_____ _____/_____/_____
Employee's Signature Date

Employee Name: _____
(Last) (First) (Middle)

Department/Division _____ Location _____

Job Title (as stated by employee) _____

Initial or ***Follow-Up*** Visit (circle one)

Insurance Company Name: _____ Claim #: _____

Date of Injury: _____/_____/_____ Date of Visit: _____/_____/_____

Description of Accident:

_____

_____

WORK STATUS: Having evaluated/treated this employee today, in my opinion:

☐ Employee may continue unrestricted regular work duty.

☐ Employee may return to work to his/her regular position on _____/_____/_____ without restriction.

☐ Employee is **Temporarily Totally Disabled** until _____/_____/_____ or pending reevaluation here on _____/_____/_____.

☐ Employee has a **Partial Disability and may return to work on a modified duty basis.*** If this is checked, please complete SCWA LIGHT DUTY STATUS section found on Page 2.

☐ Employee is on medication (s) that will restrict his/her ability to work safely. Explain: _____

_____

_____

Employee will be seen in this office for follow-up on _____/_____/_____

*** The Suffolk County Water Authority has an extensive Modified Duty Program which is made available to all employees with physical limitations. For qualifying employees, it is imperative that the limitations are listed so that we may properly assign duties consistent with our employee's limitations. Please complete SCWA's Light Duty status form.**

In accordance with the Labor agreement between the Suffolk County Water Authority and the Utility Workers' Union of America, A.F.L. – C.I.O., Local 393, updated medical reports must be submitted to the Authority every four (4) weeks for employees receiving workers compensation benefits or who are on light duty.

Suffolk County Water Authority

Workers Compensation – Employee Medical & Work Status Form

To be Completed by Attending/Treating Physician

Employee Name: _____
(Last) (First) (Middle)

LIGHT or MODIFIED DUTY WORK STATUS: The Suffolk County Water Authority has a light duty work program for those individuals who have physical restrictions that prevent them from performing all of the tasks associated with their job.

Having evaluated/treated this employee today, in my opinion:

☐ Employee can return to work on _____/_____/_____ with the **following functional capabilities:** In an 8 hour day, employee may:

	1-2 hours	2-4 hours	4-6 hours	6-8 hours	None
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Bend/Squat	☐	☐	☐	☐	☐
Climb	☐	☐	☐	☐	☐
Reach	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐
Use Foot/Feet	☐	☐	☐	☐	☐
Use Hand(s)	☐	☐	☐	☐	☐

☐ Patient is able to lift. ☐ Patient is unable to lift greater than _____ pounds.

Patient may use ☐ RIGHT ☐ LEFT ☐ BOTH foot/feet for repetitive movement as in operating foot controls.

Patient may use ☐ RIGHT ☐ LEFT ☐ BOTH hand(s) for repetitive ☐ single grasping ☐ fine manipulation ☐ pushing and pulling.

The restrictions above are in effect until _____/_____/_____ or pending reevaluation here on _____/_____/_____.

DIAGNOSIS: _____

_____

TREATMENT PLAN: _____

_____

Provider Name (print): _____ **Provider Address:** _____

Provider Signature: _____ Date: _____/_____/_____

Please Return This Form To: Suffolk County Water Authority, Risk Management Department, 4060 Sunrise Highway, Oakdale, NY 11769. Fax: (631) 218-1155