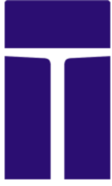


TWINSBURG CITY SCHOOL DISTRICT
11136 Ravenna Road • Twinsburg OH 44087-1022
Phone 330.486.2000 • Fax 330.425.7216

Kathryn M. Powers
Superintendent

Julia Rozsnyai
Treasurer

Matthew Strickland
Business Manager

Jennifer C. Farthing
Director of Curriculum

Ryan Bandiera
Director of Pupil Services

Michael Sedlak
Director of Human Resources

INJURY PACKET INSTRUCTIONS

Any employee incurring an injury while engaged in his/her performance of District duties shall abide by the following procedures:

1. The injured employee shall report to his/her supervisor's office, obtain an Injury Packet, and complete the following forms before reporting to an approved physician:
   - Incident Report Form
   - Witness Statement
   - Provider Listing
   - BWC FROI (form #1101)
   - BWC Authorization to Release Medical Information (form #C101)
   - Sick Leave Option Form

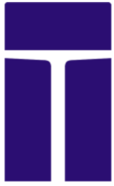
   The only exception will be if the injure is of such a nature that it requires immediate emergency attention. In that case, treatment should be undertaken and a report of the accident made to the supervisor's office at the earliest opportunity.

   Except in emergencies, staff members are required to use only hospitals and physicians approved by the Bureau of Workers Compensation and the insurance carrier in the treatment of work-related injuries. Each school and department shall maintain a list of those hospitals and physicians approved for treatment of school employees.

2. Upon arrival at a medical provider the employee should:
   - Inform the physician that this is a work injury
   - Inform the physician that CompManagement Health Systems if our Managed Care Organization (MCO) and to call 1-888-247-4800 to report treatment.

3. Upon completion of medical care by a specialist, the employee must first report back to the treating physician for release prior to returning to work.

4. If medical treatment is required for two weeks or more, the employee is eligible to participate in the Transitional Work Program.



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INCIDENT REPORT FORM

EMPLOYEE INFORMATION

Injured Employee's Name	Injured Employee's Position
Injured Employee's Phone #	Injured Employee's Address
Supervisor Notified	Date / Time Supervisor Notified

ACCIDENT INFORMATION

Location Injury Occurred	Date / Time of Injury

Describe Nature and Cause of Injury in Detail (Please Print or Type)

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____

____

____

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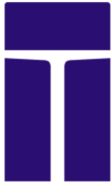
Facility Taken To	Facility Address
Facility Phone #	Treating Physician
Employee Completing this Report – Name	Employee Completing this Report – Title
Date Received by Accountant	Accountant Signature



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INCIDENT WITNESS STATEMENT

Witness Name	Title
Injured Employee's Name	Date of Injury

Did you witness the injury? ______________________________

Were there any other witnesses? ______________________________

If yes, please name: ______________________________

What date and time were you first aware that your co-worker was injured? ______________________________

Please describe the nature and cause of the injury in your own words:

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Employee Signature	Date Completed
Accountant Signature	Date Received by Accountant