

DALTON POLICE DEPARTMENT

	<i>Effective Date</i> December 1, 1998	<i>Number</i> GO98-3.15
<i>Subject</i> Workers' Compensation		
<i>Reference</i>		<i>Revised</i> November 28, 2017 26, 2019
<i>Distribution</i> All Personnel	<i>Re-evaluation Date</i> November 28, 2019 2021	<i>No. Pages</i> 7

I. Policy

It is the policy of the City of Dalton to provide workers' compensation to those who are injured on the job.

II. Procedure

A. Employee Responsibilities

1. The employee shall report all injuries to a Supervisor immediately, regardless of whether or not medical attention is needed.
2. ~~The~~ An injured employee in need of medical treatment ~~should~~ shall report to one of the physicians listed on the City of Dalton's panel of physicians. ~~This~~ The panel of physicians is posted on several bulletin boards located throughout the Police Services Center. If immediate medical attention is needed, and the offices of the physicians listed on the City of Dalton panel are closed, the employee ~~should~~ shall go to the emergency room at Hamilton Medical Center.
3. The employee may be required to submit to a drug screen pursuant to policy GO97-3.8, Drug Free Workplace Policy and Procedure on Substance Abuse, Contraband Articles, and Employee Assistance; III, I, 5.

B. Supervisor Responsibilities

1. Determine if medical attention is needed and direct the employee to one of the physicians listed on the panel.
2. When applicable, advise the employee to submit to a drug screen pursuant to policy GO97-3.8, Drug Free Workplace Policy and Procedure on Substance Abuse, Contraband Articles, and Employee Assistance; III, I, 5.
3. ~~Complete~~ Start the workers' compensation form WC-1, Employer's First Report of Injury or Occupational Disease, regardless of whether or not medical attention is needed or received (Appendix A).

RESTRICTED LAW ENFORCEMENT DATA

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4. The following ~~areas~~ sections of form WC-1 shall ~~must~~ be initially completed by a Supervisor: ~~;- at a minimum:~~
 - a. Employee's name (last, first, and middle initial)
 - b. Date of injury
 - c. County of injury
 - d. On employer's premises? (yes or no)
 - e. Time of injury
 - f. First date employer made aware
 - g. First date employee failed to work a full day
 - h. How did the injury or illness / abnormal health condition occur? Include address or location, if applicable.
 - i. Describe the injury or illness in detail.
 - j. Include the source of the injury and indicate the part of body affected.
 - k. Treating physician (name and address)
 - l. Level of initial treatment given
 - 1) ~~None,~~
 - 2) ~~Minor: By Employer,~~
 - 3) ~~Minor: Clinical/Hospital,~~
 - 4) ~~Emergency Room, or~~
 - 5) ~~Hospitalized > 24 hrs.~~
 - m. Hospital (name and address)
- 4.5. Contact the Chief of Police's administrative assistant by leaving a voice mail or an email to advise that an injury has occurred and that the WC-1 has been ~~completed~~ started and is being forwarded.
- 5.6. Forward the ~~completed~~ WC-1 to the Chief of Police's administrative assistant immediately.
- 6.7. Follow up with the employee.
 - a. Find out medical status
 - b. Offer to help
 - c. Report any change of status to the Chief of Police's administrative ~~secretary~~ assistant

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C. Chief of Police's Administrative ~~Secretary~~ Assistant's Responsibility

1. Complete the remainder of the WC-1 and any additional forms.
2. Forward the completed WC-1 to the workers' compensation insurance carrier.
3. Monitor any expenses associated with the claim and report any inconsistencies to the Chief of Police, Human Resources Director, and Division ~~a~~ Commander of employee.

D. Return to Duty Procedure

Employees returning to work following a serious health condition or work-related injury shall have the Human Resources FMLA Return to Work Medical Evaluation form completed by their physician (Appendix B). Sworn employees ~~will~~ shall also be required to have the attending physician complete the physical readiness assessment Medical Release Form (Appendix C). The applicable form(s) must be submitted to the employee's Division Commander prior to the employee's return to duty.

~~The following areas must be completed at a minimum:~~

- ~~1. Employee name~~
- ~~2. Date the employee is cleared to return to work~~
- ~~3. Restrictions if any~~
- ~~4. Contradictions / No Contradictions Portion of the form~~
- ~~5. Physicians signature~~

This policy supersedes any previous policies issued.

BY ORDER OF

CHIEF OF POLICE

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Appendix A

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
A. IDENTIFYING INFORMATION					
EMPLOYEE <input type="checkbox"/> Male <input type="checkbox"/> Female Birthdate _____ Phone Number _____ Employee E-mail _____					
Address _____			City _____	State _____	Zip Code _____
EMPLOYER Name _____		NAICS Code _____	Nature of Business (Trade, Transport, Mfg, etc.) _____		
Address _____			Phone Number _____	Employer FEIN _____	
City _____ State _____ Zip Code _____			Employer E-mail _____		
INSURER / SELF-INSURER Name _____		Insurer/Self-Insurer FEIN _____		Insurer/ Self-Insurer File # _____	
CLAIMS OFFICE Name _____		Claims Office FEIN # _____	Claims Office Phone _____	Claims Office E-mail _____	
COLLINS & COMPANY		62-0882150	706-277-1197	mharvey@collinsandco.com	
SSWC ID# (five digit no.) 21355	Address P.O. Box 6429		City Dalton	State GA	Zip Code 30722
EMPLOYMENT/WAGE Date Hired by Employer _____ Job Classified Code No. _____		Number of Days Worked Per Week _____		Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month	
Insurer Type Code <input type="checkbox"/> I - Insurer <input checked="" type="checkbox"/> S - Self-Insurer <input type="checkbox"/> G - Group Fund			List Normally Scheduled Days Off _____		
INJURY/ILLNESS & MEDICAL Time of injury <input type="checkbox"/> am <input type="checkbox"/> pm		County of injury WHITFIELD	Date Employer had knowledge of injury _____	Enter First Date Employee Failed to Work a Full Day _____	
Did Employee Receive Full Pay on Date of Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type of Injury/Illness _____ Body Part Affected _____	
How Injury or Illness / Abnormal Health Condition Occurred _____					
Treating Physician (Name and Address) _____		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> Hospitalized > 24hrs		Hospital / Treating Facility (Name and Address) _____	
				If Returned to Work, Give Date: Returned at what wage _____ per Week If Fatal, Enter Complete Date of Death _____	
Report Prepared By (Print or Type) _____			Telephone Number _____	Date of Report _____	
B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum					
Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> No		Average Weekly Wage: \$ _____ Weekly benefit: \$ _____		Date of disability: _____	
Date of first Payment: _____		Compensation paid: \$ _____ or Date salary paid: _____		Penalty paid: \$ _____	
BENEFITS ARE PAYABLE FROM _____ FOR: _____					
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> Permanent partial disability of _____ % to _____ for _____ weeks.					
UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.					
C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION					
Benefits will not be paid because: _____					
D. MEDICAL ONLY <input type="checkbox"/> No disability paid or controverted					
(Insurer / Self-Insurer: Type or Print Name of Person Filing Form) Makeva Harvey			Signature _____		Date _____
Phone and Ext. (678) 302-6815		E-mail mharvey@collinsandco.com			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3616 OR 1-800-533-0682 OR VISIT <http://www.sbwc.georgia.gov> WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. 134-4-13 AND 134-4-19).

WC-1

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**EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE**

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WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE
GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION
Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818
<http://www.sbcw.georgia.gov>

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov> WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. 134-8-19 AND 134-8-19).

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**EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE**

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Appendix B



**Human Resources
 FMLA
 Return to Work
 Medical Evaluation**

Date _____

Dear: _____

This letter is in reference to _____ our employee and your patient. We are investigating the eligibility of this employee to return to work following a "serious health condition, which made the employee unable to perform the functions of such employee's position".

A "serious health condition" when utilized as a basis for family leave, means an illness, injury, impairment, or physical or mental condition involving either inpatient care in a hospital, hospice, or residential health care facility, or continuing treatment by a health care provider.

The essential functions of this employee's job are as follows. Please indicate in your opinion if he/she will be able, or not, to perform these functions, and any restrictions you recommend, as of the expected return to work date of _____.

To be completed by supervisor	To be completed by health care provider	
JOB TASK/RESPONSIBILITY	<input type="checkbox"/> Yes <input type="checkbox"/> No	RESTRICTIONS
JOB TASK/RESPONSIBILITY	<input type="checkbox"/> Yes <input type="checkbox"/> No	RESTRICTIONS
JOB TASK/RESPONSIBILITY	<input type="checkbox"/> Yes <input type="checkbox"/> No	RESTRICTIONS

Thank you for your help in this process. Should you have any questions regarding this request, please contact me directly.

 Supervisor Name Title Phone

In your opinion, when will he/she be able to return to work and resume his/her normal duties? _____

Name of health care provider _____ Phone _____

Signature _____ Date _____

Patient /employee signature authorizing release of information _____

Please return this completed form to the patient, in person or to the following address: _____

 Patient name

 Patient address

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Appendix C

MEDICAL RELEASE FORM

Individual's Name _____

Dalton Police Officers are required to perform a variety of essential physically demanding tasks, including the following:

- Walking for extended periods
- Short sprints
- Long pursuits lasting over 2 minutes
- Running up and down stairs
- Pushing heavy objects
- Jumping over and around obstacles
- Lifting and carrying heavy objects, sometimes up and down stairs
- Using hands and feet in use of force situations
- Using force in short and long term (greater than 2 minutes) efforts
- Bending and reaching
- Dragging people and objects

To measure an individual's capability to perform these critical tasks, all applicants and incumbents must undergo a physical readiness assessment consisting of the following items:

1. 1.5 mile run to measure aerobic power
2. 300 meter run to measure anaerobic power
3. Maximum push-ups to measure upper body muscular endurance
4. 1 repetition maximum bench press to measure upper body strength
5. Maximum sit-ups test to measure trunk muscular endurance
6. Vertical jump test to measure the explosive power of the lower extremities

Your professional opinion is requested as to whether the individual can safely participate in physical fitness testing and exercise training.

PLEASE CHECK ONE:

_____ There are **no contraindications** to the individual either 1) being capable of performing the essential physical tasks and 2) being capable of undergoing the physical readiness assessment items.

_____ There are contraindications and it is not recommended that the individual participate in the physical readiness assessment or exercise training at this time.

Physician's signature _____

Date: _____

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