DALTON FIRE DEPARTMENT

Standard Operating Procedure

S.0.P.:	**GP- 12**
Effective:	**06-27-2017**
Revised:	**06-23-2020**
Reviewed:	**06-23-2020**

_____ _____

Fire Chief Signature **DATE**

Title: On Duty Injury / Workers' Compensation Procedures

Scope: All Personnel

Policy:

While you are actively at work, you are covered (with limited exceptions) under the city's workers compensation policy. This policy is designed to cover you should you become injured on the job. If you should become injured in any way, report the injury to your supervisor as soon as possible, but no longer than 24 hours after the occurrence.

Personnel should refer to the Georgia State Board of Workers' Compensation Official Notice posted in all locations for a list of approved physicians.

PROCEDURE:

Responsibilities of the injured employee:

Immediate advanced treatment required:

- If needed, contact 911 for an ambulance.
- Notify your supervisor immediately.
- ~~An Authorization for Treatment form shall be filled out and taken to the medical facility by the employee or a supervisor.~~
- Complete Georgia State Board of Workers' Compensation form WC-1 and submit to your supervisor as soon as possible after the injury. All injuries must be reported within 24 hours. If the employee is unable to complete the form due to the injury, the supervisor shall complete the form.
- See addendum attached to this SOP located in Target Solutions

Advanced treatment is not immediately required:

- Notify your supervisor immediately.
- Treat the injury.

- Complete the Georgia State Board of Workers' Compensation form WC-1 and submit to your supervisor as soon as possible after the injury. All injuries must be reported within 24 hours. If the employee is unable to complete the form due to the injury, the supervisor shall complete the form.

- If medical treatment is needed at a later date, contact administration for further assistance.

Responsibilities of the Supervisor:

Immediate advanced treatment required:

- Evaluate and provide first aid.

- Notify 911 for an ambulance if necessary.

- Notify the Shift Commander of the injury.

- ~~Complete the An Authorization for Treatment form (if not done so by the employee) that must be filled out and taken to the medical facility by the employee or a supervisor.~~

- Complete the Georgia State Board of Workers' Compensation form WC-1 (if not done so by the employee) and submit to administration within 24 hours of the incident.

- See addendum attached to this SOP located in Target Solutions

Advanced treatment is not immediately required:

- Treat the injury.

- Ensure the Georgia State Board of Workers' Compensation form WC-1 has been completed and submitted to administration within 24 hours of the incident.

- Notify the Shift Commander.

Follow Up Physician and Rehabilitation

- It is the responsibility of the employee to schedule follow up and rehabilitation appointments. Do not pay for any treatment with your health insurance when being treated for a workers compensation claim.

- ~~Professional Pharmacy accepts and files with Collins and Co. for Workers' Compensation prescriptions. This is at no cost to the employee. Your pharmacy may not file and you may be required to pay any prescription cost and submit for reimbursement to administration.~~

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WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

CLEAR

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.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE

❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail

Mailing Address	City	State	Zip Code

EMPLOYER

Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
City of Dalton-Fire Department	922160	City Municipality

Mailing Address	Phone Number	Employer FEIN
P O Box 1205	706-278-7363	58-6000557

City	State	Zip Code	Employer E-mail
Dalton	GA	30722	mcrussell@daltonga.gov

INSURER / SELF-INSURER

Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
City of Dalton	58-6000557	

CLAIMS OFFICE

Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
Corvel		1800-685-4267 opt 2	fnol_fax@corvel.com

SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code
	P O Box 3279	Duluth	GA	30096

EMPLOYMENT/WAGE

Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease:
	7710-Firefighters & Drivers		❑ per Hour ❑ per Day ❑ per Week ❑ per Month

Insurer Type Code	List Normally Scheduled Days Off
❑I – Insurer ☑S-Self-insurer ❑Group Fund	

INJURY/ILLNESS & MEDICAL

Time of Injury	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
❑ am ❑ pm			

Did Employee Receive Full Pay on Date of Injury?	Did Injury/Illness Occur on Employer's premises?	Type of Injury/Illness	Body Part Affected
❑ Yes ❑ No	❑ Yes ❑ No		

How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address)	Initial Treatment Given:	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date:
	❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ Hospitalized > 24hrs		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 ❑ Yes ❑ 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:

❑ Temporary total disability ❑ Temporary partial disability ❑ 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 INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Corvel-Lisa Smith		

Phone Number	E-mail
770-225-5950	lisa_smith@corvel.com

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.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. §34-9-18 AND §34-9-19).

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

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct Insurance Company and their SBWC ID number.

Complete Section B, Co or D and file with the Board and send a copy of both sides of the form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-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.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

GMA Workers' Compensation Self-Insurance Fund (GMA WCSIF)

Contact List

For Reporting Of New Claims, Please Contact:

Corvel Reporting Line: (24 hours)	**1-800-685-4267 option 2**
Fax: (24 hours)	**1-866-777-1668**
Email:	fnol_fax@corvel.com
24/7 Nurse Advocacy/Telehealth Line	**1-800-685-4267 option 1**

Corvel Claim Office
P.O. Box 3279
Duluth, GA 30096
800-685-4267 (toll free) 770-225-5941 (bill inquires)

For general questions or to request a certificate of coverage, please contact: 1-888-488-4462 (outside metro Atlanta)

Dana Goodall, Risk Management Assistant *dgoodall@gacities.com*	**678-686-6220**	**678-686-6320**
Stan Deese, Director, Risk Management Services *sdeese@gacities.com*	**678-686-6221**	**678-686-6321**
Brenda Eckman, WC Claims Manager & Liaison *beckman@gacities.com*	**678-686-6224**	**678-686-6324**

For billing and accounting questions, please contact: 1-888-488-4462 (outside metro Atlanta)

Joel Levy, Accounting Technician (deductible billing inq.) *jlevy@gacities.com*	**678-686-6233**	**678-686-6333**
Dana Goodall, Risk Management Assistant *dgoodall@gacities.com*	**678-686-6220**	**678-686-6320**

Georgia Municipal Association
PO Box 105377
Atlanta, Georgia 30348
404-688-0472 (phone) 678-686-6289 (fax)

AUTHORIZATION FOR MEDICAL TREATMENT

PLEASE RENDER TREATMENT AS MAY BE REQUIRED:

_____

EMPLOYEE'S NAME

PLEASE NOTE: ANY TREATMENT OR DIAGNOSTIC SERVICE PERFORMED OUTSIDE YOUR FACILITY MUST BE PRE-APPROVED BY:

CorVel Corporation
P.O. Box 3279
Duluth, Ga 30096
678-942-7300
Bill Inquiries: 770-225-5941 Fax: 866-434-4759 Email: Duluth_bill_review@corvel.com

_____

Signature of Claims Adjuster approving initial treatment **Date**

BASED UPON THE CURRENT EVALUATION, THE EMPLOYEE CAN PERFORM THE FOLLOWING WORK:

FOR PHYSICIAN:

WORK RESTRICTIONS

_____ **NORMAL –** NO RESTRICTIONS

_____ **MEDIUM –** LIFTING UP TO FIFTY (50) POUNDS MAXIMUM WITH FREQUENT LIFTING AND/OR CARRYING OF OBJECTS WEIGHTING UP TO 25 POUNDS.

_____ **LIGHT –** LIFTING OF TWENTY POUNDS MAXIMUM AND CARRYING OF OBJECTS WEIGHING UP TO TEN POUNDS. A JOB IN THIS CATEGORY COULD REQUIRE STANDING OR WALKING TO A SIGNIFICANT DEGREE, PUSHING OR PULLING OF ARM AND LEG CONTROLS.

_____ **SEDENTARY –** LIFTING TEN POUNDS MAXIMUM, LIFTING AND CARRYING OF ARTICLES SUCH AS LEDGERS AND BOOKS. SOME STANDING AND WALKING.

_____ **ADDITIONAL RESTRICTIONS:** _____

_____

DIAGNOSIS: _____

_____

PROGNOSIS: _____

_____

NEXT APPOINTMENT (DATE AND TIME): _____

_____ _____

PHYSICIANS SIGNATURE **DATE**

Injured Worker's First Fill Prescription Form

NOTICE TO INJURED WORKER & PHARMACIST*:*
This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one time fill of prescription medications. For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Injured Worker's Name: _____

SS#: _____ ***Date of Injury:*** _____

INJURED WORKER INSTRUCTIONS:

On your first Pharmacy visit, **please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by Georgia Municipal Association.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a **14** day supply of medications.

PHARMACIST INSTRUCTIONS:

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**
Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC8738587**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's 9 digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription: **XXXXXXXXXMMDDYYYY**

There are over 72,000 Participating Pharmacies in the CorVel Network. Below is a sample listing. Call (800)563-8438 for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL

WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change of doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

State Board of Workers' Compensation
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
or 1-800-533-0682
http://www.sbwc.georgia.gov

Dalton Family Practice
Family Practice
1114 Professional Blvd
Dalton, GA 30720
(706) 278-0138
name/address/phone

Associates in Orthopedics & Sports Medicine
Orthopedics/Orthopedic Surgery
1104 Professional Blvd
Dalton, GA 30722
(706) 226-5533
name/address/phone

Center for Sports Medicine & Ortho
Orthopedics/Orthopedic Surgery
4725 Battlefield Parkway
Ringgold, GA 30736
(423) 624-2696
name/address/phone

Dr. Leland Duddleston
Dr. Murray Watson
Priority Care - Dalton
Primary Care
1000 Riverburch Pkwy
Dalton, GA 30722
(706) 226-2273
name/address/phone

Vaughn Orthopedic & Spine Center
Orthopedics/Orthopedic Surgery
935 Spring Creek Rd, Ste 200
Chattanooga, TN 37404
(423) 664-4787
name/address/phone

Professional Eye Associates
Ophthalmology/Ophtal Surgery
1111 Professional Blvd
Dalton, GA 30720
(706) 226-2020
name/address/phone

Mednow
Urgent Care/Occupational Medicine
2709 Airport Rd Ste 101
Dalton, GA 30721
(706) 275-4444
name/address/phone

Hamilton Convenient Care
Orthopedics/Orthopedic Surgery
1012 Burleyson Drive
Dalton, GA 30720
(706) 529-3245
name/address/phone

(Additional doctors may be added on a separate sheet)

The insurance company providing coverage for this business under the Workers' Compensation Law is:

TPA CorVel Corporation
Name

PO Box 898 — Duluth, GA 30096 — (800) 275-8836
address — phone

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.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. §34-9-18 and §34-9-19).

WC-P1 (7/2006)