DALTON POLICE DEPARTMENT

	Effective Date	Number
	December 1, 1998	**GO98-3.15**
Subject **Workers' Compensation**		
Reference **CALEA Standard – 22.2.1**		*Revised* **November ~~26, 2019~~ December 28, 2021**
Distribution **All Personnel**	*Re-evaluation Date* **November ~~2021~~ December 2023**	*No. Pages* **7**

I. Policy

It is the policy of the ~~City of~~ Dalton Police Department to ~~provide workers' compensation to those who are injured on the job~~ document, report, and assist an employee with obtaining necessary medical treatment for all injuries and illnesses that arise out of an employee's being engaged in the course and scope of his or her employment, in accordance with the policies and procedures of the City of Dalton and in compliance with the Georgia Workers' Compensation Act, Chapter 9 of Title 34 of the Official Code of Georgia.

II. Procedure

A. Employee Responsibilities

1. The employee shall report all work-related injuries and illnesses to a Supervisor immediately, regardless of whether or not medical attention is needed.

2. An injured employee in need of medical treatment shall report to one of the physicians listed on the City of Dalton's panel of physicians. 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 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 or, if an emergency, to the emergency room at Hamilton Medical Center or other proper treating facility.

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. 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).

4. The following sections of form WC-1 shall be initially completed by a Supervisor:

    a. Employee's name (last, first, and middle initial)

    b. Date of injury or illness

    c. County of injury or illness

    d. On employer's premises? (yes or no)

    e. Time of injury or illness

    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 or illness and indicate the part of body affected.

    k. Treating physician (name and address)

    l. Level of initial treatment given

    m. Hospital (name and address)

5. Contact the Chief of Police's administrative assistant by leaving a voice mail or an email to advise that an injury or illness has occurred and that the WC-1 has been started and is being forwarded.

6. Forward the WC-1 to the Chief of Police's administrative assistant immediately.

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 assistant

C. Chief of Police's Administrative Assistant Responsibilities

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 Commander of employee.

D. Return to Duty Procedure

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

This policy supersedes any previous policies issued.

BY ORDER OF

_____

CHIEF OF POLICE

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.	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.)		
Mailing 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	
SBWC ID# (five digit no.)	Mailing Address	City	State	Zip Code

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code ☐I – Insurer ☐S-Self-Insurer ☐Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	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? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				
Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ 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 ☐ 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
Phone Number	E-mail	

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 §34-9-18).

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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

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

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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	❑Yes ❑No	**RESTRICTIONS**
JOB TASK/RESPONSIBILITY	❑Yes ❑No	**RESTRICTIONS**
JOB TASK/RESPONSIBILITY	❑Yes ❑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

_____

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~~ testing, ~~consisting~~ which may consist of the ~~following~~ performance of or simulation of the previously listed tasks ~~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~~ testing.

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

Physician's signature_____

Date:_____

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