# Little Rock School District
# WORKERS COMPENSATION PROCESS

START

Employee is injured

Notify Supervisor/ Administrator

*Administrator or employee must immediately contact ASBA.

ASBA phone number: 501-492-4887

Website: www.arsba.org/home/wcform1/

ASBA will notify the Safety and Security Office.

Injured employee completes AR-N

Supervisor/Administrator completes Worker's Comp Form

*Note: ASBA will notify Concentra for consent to treat.

Supervisor/Employee gets witness statement.

Injured employee to use accrued sick leave unless injured by assault or act of violence

Employee may review Employee Portal for available sick leave.

Supervisor/Employee submits required forms to Safety and Security within 24 hours of the injury

**Required Forms**

- First Report of Injury
- AR-N Form
- Witness Statement (if applicable)

**Submit forms to:**
Safety and Security Department
**Attention: Kristen Smith**
E-mail: kristen.smith@lrsd.org
Phone: 501-447-2075
Fax: 501-447-2076

Supervisor/Employee required forms to Safety and Security

*Send via interoffice mail. Original copies of Form-N are needed for file.

Supervisor/Administrator continues to monitor Complete "Accident Assessment Follow-up and forward to Safety and Security Office; report employee status, doctor statements, if pertinent.

STOP

Numbers to call for emergency treatment or appointment

**Life Threatening/ Emergency: Dial 911**

**Heart Attack/Stroke**
**Loss of Life or Limb**
**Difficult Breathing**
**Electrocution**
**CL2 Inhalation**
**Severe Chemical Burn**

**Concentra:**
**North Little Rock Location:**
**501-945-0661**
**LR Location:**
**501-568-7868**
**Vehicle Accidents**
**Back Injuries/Muscle Strains**
**Cuts or Contusions**
**Insect Bites or Stings**
**Minor Chemical Burn**
**Contact Dermatitis**
**Any Other Work Related Reasons Requiring Medical Attention**

KEY

| | |
|---|---|
| *ASBA | Arkansas School Board Association |
| Blue | Injured Employee |
| Yellow | Supervisor/Injured Employee |
| Tan | Witness Statement |

Little Rock School District
www.lrsd.org

Workers' Compensation Reporting Instructions

Effective January 1, 2015, Arkansas School Boards Association (ASBA) will administer the workers' compensation claims for injuries occurring January 1, 2015 and after.

(1) Injured worker reports all injuries/incidents to their immediate supervisor.
(2) Supervisor/injured worker immediately calls Claim Reporting Line at 501-492-4887
Claim Reporting Line hours:
Monday through Thursday 7:00 am – 4:30 pm
Friday 7:00 am – 4:00 pm

Claims can also be reported online at www.arsba.org/home/wcform1

If medical treatment is needed, ASBA will fax a medical authorization to the designated workers' compensation clinic.

ASBA will email the Form 1, Employer's First Report of Injury or Illness, to Kristen Smith @ LRSD Safety & Security Department.

**Form AR-N,** Employee's Notice of Injury must be completed on **ALL** work related injuries/incidents. This form is to be completed by the injured employee, even if medical treatment is not required.

**PROVIDE THE EMPLOYEE A COPY OF THE FRONT & BACK OF THE COMPLETED FORM.**
The injured employee should sign confirming they received a copy of the front and back of the completed form.

Forward the **ORIGINAL** completed Form N to Kristen Smith.

Notify Kristen Smith, Robert Robinson, Sue Rodgers and Jordan Eason immediately if the employee is unable to work due to the work related injury.

Notify Kristen Smith, Robert Robinson, Sue Rodgers and Jordan Eason of the first day the employee returns to work.

Emergency situations are to be given priority over these procedures. If an employee is incapacitated and emergency treatment is required, the employee's supervisor should follow the above reporting procedures in a timely manner.

**Little Rock School District Designated Workers' Compensation Clinics:**

Concentra Medical Center
10101 Mabelvale Plaza Drive, Ste 3
Little Rock AR 72209
Phone: 501-568-7868
Hours: Monday through Friday 8:00 am – 5:00 pm

Concentra Medical Center
3470 Landers Road
N Little Rock AR 72117
Phone: 501-945-0661
Hours: Monday through Friday 7:00 am – 6:00 pm

If the employee submits any correspondence relating to workers' compensation claim, please forward same to Kristen Smith.

If you have any questions, please contact Arkansas School Boards Association:

Amanda Blair, Adjuster 501-492-4802
Misty Thompson, Claims Supervisor, 501-492-4803
Shannon Moore, Director 501-492-4800

**FORMS TO BE POSTED AT EACH CAMPUS:**

ASBA claim reporting poster

Form AR-P, *Workers' Compensation Instructions to Employers and Employees*
Form AR-H, *Health Care Notice for Employees Under Managed Care*

| Form AR-N | ARKANSAS WORKERS' COMPENSATION COMMISSION | N |
|---|---|---|
| Ark. Code Ann. §§11-9-701, 508, 514<br>AWCC Rule 099.33<br>Revised: 1-1-2001<br>Updated: 8-1-2006 | 324 Spring Street, Little Rock, AR 72201<br>Mail: P. O. Box 950, Little Rock, AR 72203-0950<br>501-682-3930 / 1-800-622-4472 | |

# EMPLOYEE'S NOTICE OF INJURY

## EMPLOYEE INFORMATION (Please Print in Ink)

| | | | | |
|---|---|---|---|---|
| Employee's Last Name | First Name | M I | Social Security Number | Home Phone No. |
| Street Address or P.O. Box | City | State | Zip Code | |

Child Support Obligation: ☐ Current ☐ Past Due Payable to:

## EMPLOYER INFORMATION (Please Print)

| | | | |
|---|---|---|---|
| Employer's Name | | Supervisor's Name | |
| Employer's Street Address or P.O. Box | Employer's City | State | Zip Code |

## ACCIDENT INFORMATION (Please Print)

| | | | Date /Time |
|---|---|---|---|
| Place of Accident | Date of Accident | Time of Accident | Employer Notified of Accident |

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date_____ Signature _____

**Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).**

**Ark. Code Ann §11-9-106(a):** "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

DATE OF BIRTH_____ **Front side / Two-sided Form** **N**

***EMPLOYEE RECEIVED COPY OF FRONT & BACK OF THIS FORM

_____

SIGNATURE/DATE

| Form AR-N | ARKANSAS WORKERS' COMPENSATION COMMISSION | N |
|---|---|---|
| Ark. Code Ann. §§ 11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001 Updated: 8-1-2006 | 324 Spring Street, Little Rock, AR 72201<br>Mail: P. O. Box 950, Little Rock, AR 72203-0950<br>501-682-3930 / 1-800-622-4472 | |

# EMPLOYER'S NOTICE TO EMPLOYEE

**NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately. Employer: Be sure the employee receives a copy of this form [Ark. Code Ann. § 11-9--514 (c)]**

**Ark. Code Ann. § 11-9-701. Notice of injury or death.**

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

## CHOICE/CHANGE OF PHYSICIAN

**Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.**

**Ark. Code Ann. § 11-9-508. Medical services and supplies.**

"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

**Back side / Two-sided form**

# WITNESS STATEMENT

**TO BE COMPLETED BY THE WITNESS TO THE ACCIDENT**

Witness Name: _____ Date: _____

School/Department: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

## Accident Details

Name of Injured Employee: _____

Date of Accident: _____ Approximate Time of Accident: _____

Does the witness know the injured party? Yes No

## Witness Statement

How did the accident occur? What did the witness observe? What did they do? Location? *(Use additional sheets of paper, if more space is needed)*

_____

_____

_____

_____

_____

_____

_____

_____

Witness Signature: _____ Date: _____

| Form AR-P | ARKANSAS WORKERS' COMPENSATION COMMISSION<br>324 Spring Street, Little Rock, AR 72201<br>Mail: P. O. Box 950, Little Rock, AR 72203-0950<br>Little Rock Office - 1-800-622-4472 / 501-682-3930<br>Springdale Office - 1-800-852-5376 / 479-751-2790 | P |
|---|---|---|
| Ark. Code Ann. §11-9-403, 407<br>AWCC Rule7<br>Updated: 06-16-14 | | |

# WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS AND EMPLOYEES

**All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.**

(Place label indicating Insurer's Name,
Claims Office Address, Claims Office Phone Number
and Policy Expiration Date)

## IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

### The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by its employees.

### The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the grounds that for some satisfactory reason such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

### Statutory Information:

Ark. Code Ann. § 11-9-514(b) states: "Treatment or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and

(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and

(3) The alleged injury is later found to be a compensable injury; and

(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

| Form AR-H | ARKANSAS WORKERS' COMPENSATION COMMISSION | H |
|---|---|---|
| Authority: Ark. Code Ann. § 11-9-514, AWCC Rule 7, 33 Revised 1-1-2001 | 324 Spring Street, Little Rock, AR 72201<br>Mail: P. O. Box 950, Little Rock, AR 72203-0950<br>501-682-3930 / 1-800-622-4472 | |

## HEALTH CARE NOTICE FOR EMPLOYEES UNDER MANAGED CARE

Your employer has contracted with the following Managed Care Organization (**MCO**):

Name USAble c/o Systemedic Corporation

Address 10809 Executive Center Drive, Ste 105, Little Rock, AR 72211

or has been certified as an Internal Managed Care System (**IMCS**). ***You are required to receive treatment through this MCO/IMCS if you receive a work-related injury. If you do not receive treatment through this MCO/IMCS, or you do not obtain permission to change treatment provider(s), then you may be required to pay for the treatment you receive.*** Emergency treatment is exempt from this requirement.

Employees are covered under the MCO/IMCS ***after*** the employer posts Form H. Prior notice given to employees by a certified MCO shall fulfill the above notice requirements.

The telephone number of your employer's MCO/IMCS is 1-800-822-2680. You may call this number if you have questions about managed care or if you need names of physicians.

If you are injured on the job, you should notify your supervisor immediately. Your supervisor will arrange for treatment or explain what you need to do to receive treatment for your injury.

If you have a problem with or a dispute about this MCO/IMCS, you may file a complaint within thirty (30) days of the occurrence. To obtain information contact your supervisor, the MCO/IMCS, or the Medical Cost Containment Division at the AWCC (1-800-622-4472 or 501-682-3930).

If you are balance billed by a physician for a covered workers' compensation injury, you should notify your employer. Balance billing occurs when physicians are paid according to the MCO/IMCS contract or the Arkansas Workers' Compensation Fee Schedule, the amount they were paid is less than the amount of their bill, and they attempt to collect the difference from employees.

**Choice/change of physician is controlled by law.** Your employer may choose the initial treating physician. Any referral would be to parties abiding by MCO rules, terms, and conditions. Emergency medical treatment is exempted. If you want a change of physician, request it from the insurance carrier or employer. If the decision is unsatisfactory, you may petition the Commission for a change. "[T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions. Such optometric or ophthalmologic medical service provider shall be considered a certified provider by the commission." Ark. Code Ann. § 11-9-508(e) ***Treatment or services furnished or prescribed other than according to the above, EXCEPT EMERGENCY TREATMENT, shall be at your own expense.***