CITY OF DUNN
WORKER'S COMPENSATION PROCEDURES

Pursuant to North Carolina General Statute 97-1 all employers with three or more employees are required to obtain insurance to cover all job related injuries and/or occupational diseases.

The purpose of the worker's compensation act is to cover employees who suffer an injury by accident or an occupational disease. All injuries must arise out of and in the course and scope of the covered employment to be considered.

PROCEDURES

1. When an accident is reported, the Supervisor or Department Head will complete an **Employee Injury Report**. The injured employee will review the completed report for accuracy and sign it.

2. Have the injured employee sign the **Authorization for Release of Information.**

3. Provide the injured employee with their **Post-Incident Medical Treatment Kit** which includes:
   Letter of Introduction to the Physician
   Physician's Report/Pharmacy Guide
   SmithRx Instant Access Card – Temporary Pharmacy Card

4. The Supervisor or Department Head should complete the employer section of the **Physician's Report/Pharmacy Guide** and have the injured employee take this form with them to an authorized treating physician. The physician will complete the middle section.

5. If a prescription is required, the employee will need to take the **SmithRx Instant Access Card-Temporary Pharmacy Card** with them to a participating SmithRx pharmacy. The prescription will be filled with no "out of pocket" cost to the employee. Key Risk will be billed directly.

6. Supervisors or Department Heads should ***immediately*** forward these completed forms to Human Resources to be filed with the Industrial Commission:
   Employee Injury Report
   Physician's Report/Pharmacy Guide
   Authorization for Release of Information

7. All follow-up physician notes should also be forwarded to Human Resources.

MEDICAL FACILITIES

If non-emergency medical treatment is required, **ALL** employees are to go to the following medical facility:

Med-Fast Urgent Care	**Hours:**	**Mon–Tues–Wed–Fri**	**(9:00am – 5:30pm)**
605 W. Cumberland Street		**Thursday**	**(9:00am – 1:30pm)**
Dunn, NC 28334		**Saturday**	**(9:00am – 1:30pm)**
(910) 891-1391		**Sunday**	**(1:00pm – 3:30pm)**

FOR ALL EMERGENCIES AND LIFE THREATENING INJURIES, EMPLOYEE SHOULD GO DIRECTLY TO THE NEAREST EMERGENCY ROOM.

In the event that Med Fast in Dunn is closed, please send the employee to one of the following participating providers:

Med-Fast Urgent Care	Hours:	Mon-Tues-Thurs-Fri	(9:00am – 5:30pm)
602 S. Wall Street		Wednesday	(9:00am – 1:30pm)
Benson, NC 27521		Saturday & Sunday	(Closed)
(919) 894-3321			

CITY OF DUNN
EMPLOYEE INJURY REPORT

GENERAL INFORMATION

Name of Injured: _____ Date of Injury: _____ Time: _____

Department: _____ Job Title: _____

Date of Hire: _____ Phone: _____ Date Reported: _____ Time Reported: _____

Supervisor: _____ Phone: _____

Location of Accident: _____

NATURE OF INJURY

Describe, in detail, how the accident happened: _____

_____

_____

_____

List any witnesses to the accident: _____ Phone: _____

_____ Phone: _____

Was accident caused by employee's failure to use safety equipment? Yes ☐ No ☐

Was the employee following the City of Dunn Safety Policy? Yes ☐ No ☐

Type of Injury: _____Body Part(s) Injured: _____

LOST TIME

Was the employee seen by a physician? Yes ☐ No ☐ Name of Facility: _____

Has the employee returned to work? Yes ☐ No ☐ If yes, give: Date: _____ Time: _____

Is the employee released to full duty? Yes ☐ No ☐ *(Please attach Physician's Report / Pharmacy Guide)*

SIGNATURES

_____ _____
Employee Signature *Date*

_____ _____
Signature of Person Completing This Report *Date*

_____ _____
Supervisor / Department Head Signature *Date*

NCLM
NC LEAGUE OF MUNICIPALITIES

434 Fayetteville Street
Suite 1900
Raleigh, NC 27601
919-715-4000
nclm.org

LIFE & HEALTH INSURANCE
1-877-287-9503
Fax: 919-733-3108

WORKERS' COMPENSATION INSURANCE
1-888-561-1083
Fax: 919-715-8465

PROPERTY & CASUALTY INSURANCE
1-800-768-8600
Fax: 919-715-8465

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

NCLM Claim Number
Date of Loss:

I, the undersigned, authorize any physician, physician's assistant or nurse who has attended me, or any hospital at which I have been confined, to furnish to any authorized representative of the NC League of Municipalities and/or my employer, any and all information which may be requested regarding my condition and/or treatment, and to allow them to examine and copy any radiographic pictures and/or diagnostic studies taken of me, or records regarding my condition or treatment. I specifically authorize said physicians, nurses and hospitals to communicate said information by any reasonable means, including written or telephonic communication or by direct interview, whether or not I am present during or notified of such communications, and I hereby authorize the NC League of Municipalities, and/or their contracted representatives, to initiate and conduct such communications, including the coordination of authorized treatment, whether or not I am present or have notice thereof.

A copy of this waiver is to be given the same force and effect as the original.

Signature: _____ Date: _____

Printed Name: _____

Address: _____

_____

Witnessed By: _____ Date: _____

NCGS § 97-25.6. Reasonable access to medical information.
Notwithstanding the provisions of G.S. 8-53, any law relating to the privacy of medical records or information, and the prohibition against ex parte communications at common law, an employer or insurer paying medical compensation to a provider rendering treatment under this Article may obtain records of the treatment without the express authorization of the employee.

Health care providers shall provide without charge to the first requesting party among the following: employers, carriers, third party adjusting agencies, and rehabilitation nurse's medical reports as required by Article 1 of Chapter 97 of the General Statutes.
A health care provider, or its agent, may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to plaintiffs, or their attorneys; defendant employers, adjusting agencies, insurance carriers, or their attorneys; and rehabilitation nurses. But in no event shall the maximum fee for the first forty pages exceed fifty cents ($.50) per page, provided that the health care provider, or its agent, may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. The maximum fee for each copy after the first forty pages shall be twenty cents ($.20) per page.

NCLM
NC LEAGUE OF MUNICIPALITIES

Letter of Introduction to the Physician

Date: _____

Name of Provider: _____

Street Address or P.O. Box: _____

City, State Zip: _____

Dear Provider:

_____, an employee of, _____, has reported a possible work related injury or illness. We have filed a workers compensation claim with our carrier, . Any authorization for treatment or referrals for additional treatment must be directed to NC League of Municipalities/ WC claim call office at **888-561-1083**.

NC League of Municipalities/ WC will be responsible for making all compensability decisions regarding this workers compensation claim. If the claim is compensable, all medical bills will be paid directly by NC League of Municipalities/ WC under our workers compensation policy. Therefore, please forward all medical bills and medical reports **(note: bills cannot be processed without the appropriate supporting medical reports)** directly to:

NC League of Municipalities

434 Fayetteville Street Ste. 1900

Raleigh NC 27601

888-561-1083 (Phone) or 919-715-8465 (Fax)

The injured employee understands that if the claim is found not to be a compensable claim, he or she will be responsible for all bills related to your treatment.

We appreciate your cooperation and assistance. If you have any questions, please contact NC League of Municipalities/ WC call center at **888-561-1083.**

_____
(Employer)

_____
(Date)

MEDICAL AUTHORIZATION & ATTENDING PHYSICIAN REPORT

EMPLOYER, complete this section

Name of Employee/Patient:	Last:	First:
Date of Injury:	Social Security Number (last 4 digits):	
Name of Employer:		
Employer Signature:	Doctor to be Seen: Fast Med	

Employer: Prior to using this form for an injured employee, briefly identify activity that would meet possible work restrictions. Work with your Claims Representative or Loss Control Specialist.

Sedentary	Light	Medium	Heavy

AUTHORIZED PHYSICIAN, complete this section

_____has been treated today for _____

A post accident drug test ☐ has ☐ has not been completed.

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately, no restrictions
- ☐ May resume work immediately with the following restrictions:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
  - ☐ Light work (lifting less than 20 lbs.)
  - ☐ Medium work (lifting less than 50 lbs.)
  - ☐ Heavy work (lifting less than 100 lbs)
- ☐ He/she is released to work:
  - ☐ _____hours per day
  - ☐ His/her normal shift
- ☐ Repetitive Motion Restrictions:

Frequency	Left _____	Right_____
Occasional <33% of time	_____	_____
Frequent 34-66% of time	_____	_____
Constant 67-100% of time	_____	_____

- ☐ He/she may return to work full duty on (date) _____
- ☐ He/she has a return appointment on (date) _____at (time)_____

Please indicate any referrals that are required: _____

Physician Signature:	Physician Name (print or type:	Date

Contact NCLM Workers' Compensation Department for referrals, authorizations, pre-certifications or billing questions:
NCLM 434 Fayetteville St, Ste 1900 Raleigh NC 27601 (888) 561-1083 Fax (919) 715-8465 Email claimsadmin@nclm.org

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PHARMACIST:

Please process all Workers' Compensation Claims for this patient through ScriptAdvisor

Employee Name: _____

Employee ID #: **Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)**

	NDC
RxBin	023377
RxPCN	MPS
Group	001824TC

Call ScriptAdvisor at 866-846-9279 if any problems occur. PLEASE DO NOT CHARGE THIS PATIENT FOR THE PRESCRIPTION.