Cabell County School Employees:

Cabell County Schools has met with the following Healthcare Providers and recommend that all non-emergency treatment be sought at these facilities. They are aware of our Return to Work Policy and Light Duty Program. Walk-in patients, X-ray machines and Physical Therapy are just a few of the many services that are offered by these healthcare providers. If possible, bypassing the emergency room for non-emergency related treatment will save you hours of waiting while still giving you the care that you deserve.

Preferred Healthcare Providers for Workers Compensation Claims

St. Mary's Occupational Medicine; 2827 5th Avenue, Huntington WV, 304-399-7858
Med Express Urgent Care; 3120 US Route 60 East, Huntington WV; 304-522-3627
Med Express Urgent Care- West; 10 Adams Ave., Huntington WV; 304-523-8838
Davis Chiropractic; 6430 E US Route 60, Barboursville WV, 304-736-4111
Short Chiropractic; 99 Cracker Barrell Drive- Suite 200, Barboursville WV, 304-733-4616
Overstreet Family Chiropractic; 6467 Farmdale Rd., Barboursville WV, 304-840-7760

***Instructions for Accident Packet**

1) Complete the "Employee's Description of Event" and return to immediate supervisor
2) Give "Occupational Injury Investigative Report" to immediate supervisor to complete
3) Any witness to accident should complete the "Witness Interview Statement"
4) Give "Letter to Physician", "Attending Physician's Report", and both "Job Function Evaluation" forms to the initial treating physician. Ask them to fill out the "Attending Physician's Report" and return back to you. The other 3 forms are for the physician so that they understand our Return to Work program.
5) **The following completed forms must be sent to the Cabell County Schools Risk Manager- Tim Stewart. The main office at your school can assist you.**

***Employee's Description of Event (complete/return within 24 hrs of accident).**
***Occupational Injury Investigative Report (complete/return within 24 hrs of accident).**
***Witness Interview Statement- If Applicable (complete/return within 24 hrs of accident).**
***Attending Physician's Report (turn in to main office of school ASAP after initial Physician visit).**

Sincerely,

Tim Stewart
Risk Manager- Cabell County Schools

Cabell County Board of Education
Report of Injury
Employee's Description of Event

☐ **Minor** ☐ **First Aid** ☐ **Medical** ☐ **Illness** ☐ **Lost Work Day**

Name: _____ Job Title: _____

Home Address: _____
(Street) (City) (State) (Zip)

☐ Male ☐ Female Date of Birth: _____ Telephone: _____

Work Location: _____ Accident Location: _____

Date of Accident: _____ Time: _____ ☐ AM ☐ PM

Date Stopped Work Due to Injury: _____ Time Stopped Due to Injury: _____

Regular Work Schedule- Start: _____ ☐ AM ☐ PM Stop: _____ ☐ AM ☐ PM

Type of Injury (Check all that apply):

☐ Cut (Laceration)	☐ Amputation	☐ Burn (Mild)	☐ Abrasion
☐ Fracture	☐ Insect Bite	☐ Puncture	☐ Electrical Shock
☐ Dislocation	☐ Rupture	☐ Sprain/Strain	☐ Other _____
☐ Contusion	☐ Burn (Severe)	☐ Rash	

Injured Part of Body (Check all injured parts):

R	L		R	L		R	L			
☐	☐	Eye	☐	☐	Wrist	☐	☐	Calf	☐ Head	☐ Abdomen
☐	☐	Collarbone	☐	☐	Hand	☐	☐	Knee	☐ Mouth	☐ Groin
☐	☐	Shoulder	☐	☐	Thumb	☐	☐	Ankle	☐ Teeth	☐ Finger
☐	☐	Arm	☐	☐	Hip	☐	☐	Foot	☐ Neck	☐ Toe
☐	☐	Elbow	☐	☐	Leg	☐	☐	Instep	☐ Nose	☐ Chest
☐	☐	Forearm	☐	☐	Thigh	☐	☐	Ribs	☐ Back	☐ Other _____

Identify which finger or toe injured: _____

Describe the accident, explaining what you were doing, how you were doing it, where you were, etc.
Including any equipment, material and/or chemicals being used. _____

Nature of Event

☐ Fall (Same Level)	☐ Caught In	☐ Struck By	☐ Exposure
☐ Fall (Up-different level)	☐ Caught On	☐ Struck Against	☐ Exertion
☐ Fall (Down-different level)	☐ Caught Between	☐ Electrical Contact	☐ Hand Tool
☐ Slip/Trip	☐ Stepped in Hole	☐ Chemical Agent	☐ Hot Surface
☐ Cutting Edge	☐ Falling Oject	☐ Inhalation	☐ Other _____

Witnesses:	Name	Address	Phone Number
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you anticipate seeking medical attention? ☐ Yes ☐ No

Signature of Employee: _____ Date: _____

ACCIDENT MUST BE REPORTED IMMEDIATELY TO YOUR IMMEDIATE SUPERVISOR. INJURY REPORT, SUPERVISOR INVESTIGATIVE REPORT AND WITNESS STATEMENT MUST BE SENT TO RISK MANAGER WITHIN 24 HOURS OF ACCIDENT

Cabell County BOE
Occupational Injury
Investigative Report

This report must be completed and attached to the Injured Employee Report and Witness Interview Reports if applicable and sent to the Safety Manager within 24 hours of accident

To Be Completed By Immediate Supervisor

Name of Injured Employee: _____

Work Location: _____

Age: _____ Sex: ☐ M ☐ F SSN: _____ Occupation: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Date Injury Reported to Supervisor: _____

Please answer the following questions:

1) Describe Injury (type, body part, etc.) _____

2) Exact location at which accident occurred: _____

3) What happened? Describe the accident explaining what the employee was doing, how they were doing it, what initiated the accident (fall, trip, cut, exertion, etc.) and any relevant background information.

_____

_____

_____

_____

4) Did the Injured or other person do or fail to do anything that contributed directly to the accident? Be specific, (Ex: "Used ladder to short for job", "stood on folding chair") _____

_____

_____

_____

_____

5) Did any defective or otherwise unsafe condition(s) of tools, equipment, machinery, structures or work area contribute directly to the accident. If so, describe in detail. _____

_____

_____

_____

6) Were pictures taken of the scene of accident? ☐ Yes ☐ No If pictures were taken, please attach

7) Were there witnesses ☐ Yes ☐ No

If there were witnesses, did the witness complete a Witness Interview Rport ☐ Yes ☐ No

8) Additional Comments: _____

_____

_____

_____

Date of Report: Supervisor/Principal Signature:

If injured employee seeks medical treatment, have employee contact Risk Manager so proper information can be sent to Workers Compensation insurance company.

Cabell County BOE
Witness
Interview Statement

This report must be completed and attached to the Injured Employee Report and Supervisor Injury Reports if applicable and sent to the Safety Manager within 24 hours of accident

To Be Completed By Witness

Note: Complete a witness report for each witness interviewed.

1) Name of Injured Employee: _____

2) Date of Injury: _____

3) Time of Injury: _____

4) Did the individual appear to be injured? If so, how? _____

5) Describe in your own words, how the injury occurred (what was individual doing). _____

6) Name(s) of other witnesses: _____

7) Descibe in your own words, how you feel the injury could have been prevented or could be prevented in the future: _____

Witness Name: _____ Witness Signature: _____

Principal Signature: _____

ATTACH COMPLETED REPORT TO EMPLOYEE ACCIDENT REPORT AND SEND TO RISK MANAGER WITHIN 24 HOURS

LETTER TO PHYSICIAN
Re: Return-to-Work Program

To Whom It May Concern:

As a treating physician, your assistance is critical in the success of our return-to-work program. Our goal is to return our employees to productive employment as soon as appropriate following an injury or illness. Some key points we would like you to know are as follows:

- Our employee will provide you with an "accident package" at the time of their initial treatment. This package will consist of this letter, and the following forms:

    a) **Attending Physician's Report** - this should be used to outline any type of work restrictions. Please complete this form and give back to our employee.
    b) **Task Evaluation Form (Current Job)** - this form lists the type of physical activity required to perform the injured associates' job duties, without restrictions.
    c) **Task Evaluation Form (Alternative Job)** - this form lists the minimal amount of physical activity that we can accommodate with their job.

- Every effort will be made to enable the employee to return to work immediately or in the very near future; even if the worker returns to a transitional modified duty position, perhaps initially only for an hour or two a day.

- We staff the employee's case internally on a weekly basis and will contact you should a question arise relative to transitional duty or related issues.

- Any reasonable physical restrictions you deem appropriate will be considered.

- We will contact you immediately if permanent limitations of any kind are projected to see if this will in any way affect the employee's ability to ultimately return to his/her regular (usual and customary) job, in your opinion.

Ultimately, we want to work in partnership with you. Should you have any questions about our return-to-work program, or one of your patients, please call. Additionally, we invite you at any time to come to our facilities to see first hand, the kind of work that is performed.

We look forward to working with you.

Sincerely,

Tim Stewart
Risk Manager- Cabell County Schools

ATTENDING PHYSICIAN'S REPORT

Instructions- Give this form and the job function evaluation forms to initial medical provider. Return completed form to Cabell BOE Risk Manager

Patient's Name: _____
Employer: Cabell County Board of Education

Dear Doctor:

Please provide the following information related to this injury/illness. This will assist us in returning our employees to work. We have an extensive and comprehensive Return-to-Work program for employees who have been hurt on the job.

1. ____ Employee may return to normal duties at once.
2. ____ Employee may return to work with the following restrictions.

Hours/Day: No Restrictions 8 hours 6 hours 4 hours other _____

Days/Weeks: No Restrictions 5 days 4 days 3 days other _____

Lifting: No Restrictions 40 lbs 30 lbs 20 lbs 10 lbs other

Movement: No Restrictions Limited Stooping Limited Bending
Limited Overhead Reaching Other _____

Other (please specify): _____

Length of restrictions: Resume regular duties after _____ days, ***or***
Employee will be re-evaluated on (date) _____

3. The employee is totally incapacitated at this time. Employee will be re-evaluated on: (date) _____.

4. **Notice to physician and employee: This report must be returned to Employee's Employer within 24 hours of this office visit.**

   I saw the patient on: (date) _____ and have made the following diagnosis:

   DX: _____

   _____

5. Comments: _____

   _____

_____ _____
Physician's Signature Date

Cabell County Schools
Job Function Evaluation

Job Title: Bus Aide

Check one: _X_ Current Job ___ Alternative / Modified Job

Physical Demands:

Standing	X	Carrying	X
Sitting	X	Stairs	X
Driving		Pulling	X
Walking	X	Kneeling	X
Running		Twisting	X
Lifting	X	Hand Tools	
Speaking	X		

Additional Comments: None

Cabell County Schools
Job Function Evaluation

Job Title: Bus Aide

Check one: ___ Current Job _X_ Alternative / Modified Job

Physical Demands:

Standing		Carrying	
Sitting	X	Stairs	X
Driving		Pulling	
Walking	X	Kneeling	
Running		Twisting	
Lifting		Hand Tools	
Speaking	X		

Additional Comments: Walking / Stairs would only be applicable to entering and exiting the bus.