DeKalb County
8/2/1988
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ON THE JOB INJURY POLICY

I. The employee's salary may be continued during their absences upon presentation to the local board of satisfactory evidence demonstrating that such absences are due to or arising from a job related injury, provided that --

A. The employee files a claim that is approved by the Board.
B. The employee chooses not to claim regular sick leave.
C. The forms are filed within the proper time limits.

II. Claims – Employee's salaries may be continued during absences due to job related injuries upon approval of proper claim. Forms to be requested from Superintendent's Office.

III. Evidence – Supporting evidence must be provided as follows:

A. Local school officials and Superintendent shall be notified immediately upon occurrence of an accident while employee is on the job.
B. Medical examination shall take place within 24 hours, if not immediately following the accident.
C. If a claim is to be filed, the intent shall be made known to the superintendent, in writing, within 3* days following the accident. The superintendent will, in turn, submit claim to the Board of Education.
D. A physician's statement shall be made available relative to the extent of the injury and the necessity for employee remaining off the job for a specified period of time. The Board reserves the right to request additional information before final approval.
E. The Board may require a second written physician's statement should the employee request to be away from his/her job for more than 10 working days.
F. Statements from witnesses, both adult and students, shall be attached to the employee's claim.

IV. Salary continuation may be made only for temporary disabilities where there is a reasonable expectation that the employee will return to work, and that the salary continuation shall not exceed ninety (90) working days.

V. Payments to an employee shall not exceed 100 percent of that employee's regular daily salary for each day absent from the job related injury.

VI. **State Board of Adjustment** - Employees may file a claim for payment of medical bills/compensation with the State Board of Adjustment when all other means have been exhausted, including insurance. On-the-Job Injury Claim **does not** pay medical bills.

VII. A job related injury absence shall be treated as sick leave for purposes of claiming reimbursement for substitute teachers and no deduction shall be made from an employee's accumulated sick leave. However, this does not preclude an employee who is absent due to a job related injury from choosing to use regular sick leave in lieu of filing an On-the-Job Injury Claim.

* Three working days

LOCAL EDUCATION AGENCY
PHYSICIAN CERTIFICATION FORM

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____-_____-_____	3. Date of Birth _____/_____/_____	4. Sex ____M ____F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) _____ Work ( ) _____	7. Job Title	8. Status _____Full Time _____Part Time _____Contract
9. Employing Agency	10. Agency Address (Number and Street) (City or Town) (State) (Zip)		

11. Date of Injury	12. Is there reasonable expectation that the employee will be able to return to work?	13. If "yes" on Item 12, give the date or approximate date of return.
_____/_____/_____	_____Yes _____No	_____/_____/_____

14. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?

15. If "no" on Item 12, give details for employee not being able to return to work.

16

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Signature of Attending Physician | Print Name | Telephone Number | Date

LOCAL EDUCATION AGENCY
INJURY REPORT

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____-_____-_____	3. Date of Birth _____/_____/_____	4. Sex ____M ____F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) _____ Work ( ) _____	7. Job Title	8. Status _____Full Time _____Part Time _____Contract
9. Employing Agency	10. Agency Address (Number and Street) (City or Town) (State) (Zip)		
11. Date of Injury _____/_____/_____	Time of Injury _____ _____a.m. _____ p.m.	13. Date Employee Notified _____/_____/_____	
14. Is employee covered by insurance? _____Yes _____ No If yes: _____ Blue Cross/Blue Shield _____ Other		15. Name and address of attending Physician	
16. Name and address of medical facility where treated ___Hospitalized ___ Outpatient ___Emergency Treatment	17. City or Town where injury occurred	18. Location or place where injury occurred	
19. (a) Describe fully what happened to cause the injury or illness. 19. (b) Were lifting belts used? _____			
20. Describe the injury or illness in detail and indicate the body part(s) affected.			
21. Were there any witnesses to the injury? ____ Yes ____ No (If "yes" give name, address, and telephone number)			
22 _____ Signature of injured person Print Name Telephone Number (Daytime) Date			
23 _____ Signature of Supervisor (or other designated authority) Print Name Telephone Number (Daytime) Date			

Number of days On-the-Job Injury Requested _____