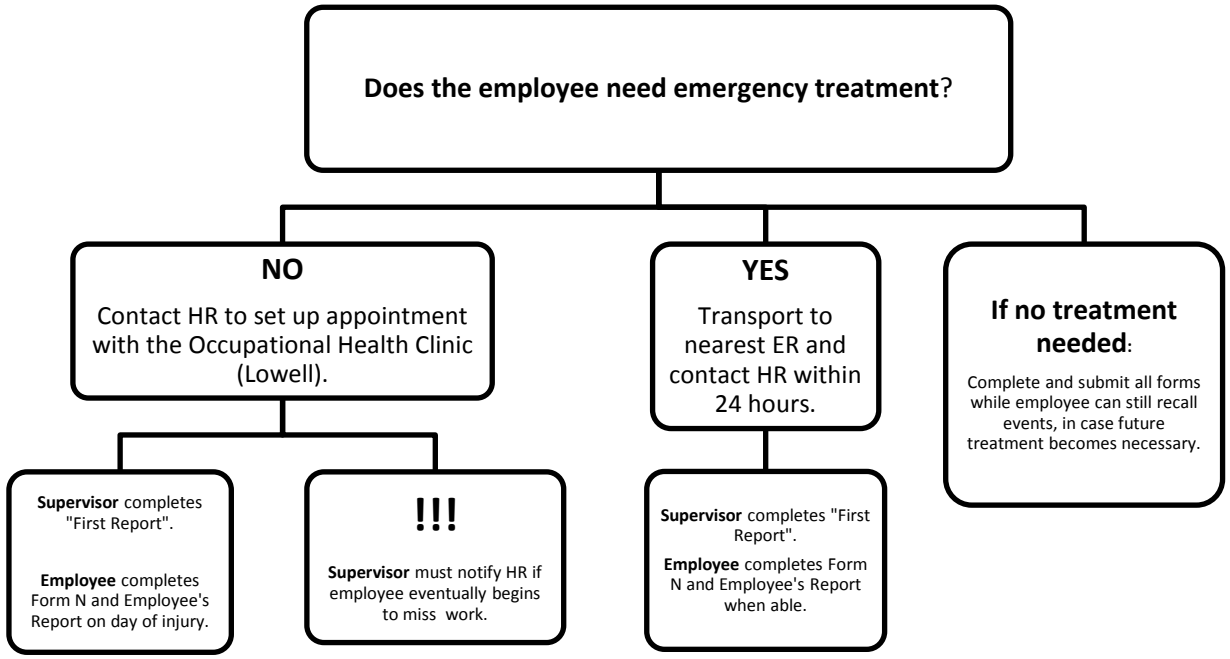
City of Rogers
Worker's Comp Packet and Instructions

When a work related injury occurs, it is the responsibility of the Supervisor to make sure all required forms are completed. In most cases, this can be done at the time of injury. The contents of this packet include everything needed to file a worker's comp claim. The diagram below shows you the typical process to be followed:



All three forms needed to file a claim are included in this Packet. These documents should be returned together to HR within 48 hours of an injury. When the City fails to report lost-time injuries within certain timeframes, penalties can be assessed by the State.

Form N--Employee's Notice of Injury ***Completed by* Employee** ***Required by State of Arkansas***

The purpose of Form N is to explain the Employee's rights, and to provide the Municipal League with authorization to obtain medical records (required for treatment). **Page two of the Form N is kept by the employee.** If the employee is physically or mentally unable to sign the Form N due to the injury, it is appropriate to a wait until they are able to do so. All other forms must be submitted to HR **within 48 hours of the injury**.

Employee's Report of Accident ***Completed by* Employee** ***Required by Municipal League***

The signature date should reflect the date the form is completed. This form should be completed and submitted to Human Resources **within 48 hours of the injury**.

First Report of Injury or Illness ***Completed by* Supervisor** ***Required by State of Arkansas***

Fill in all yellow sections, and be as descriptive as possible. ***Date Administrator is Notified* is the date the form is turned into HR,** not the date the supervisor is notified. This form should be completed and submitted to HR **within 48 hours of the injury** regardless of whether or not the employee seeks medical treatment at that time.

NOTE: Employees seeking treatment from a personal physician risk these expenses not being covered by the Municipal League. Once a claim is filed, the employee may request a one (1) time change of physician as explained on Form N.

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 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."

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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

MUNICIPAL EMPLOYEE'S REPORT OF ACCIDENT
mail to: **Municipal League Workers' Compensation Trust**
P.O. Box 37
North Little Rock, AR 72115

To be completed by employee:

PERSONAL: Name _____ Phone # _____ Birth Date _____
Last First Middle

Address: _____ Marital Status _____ Sex ___
Street City State Zip

EDUCATION: Circle highest grade level completed. 1 2 3 4 5 6 7 8 High School 9 10 11 12 College 1 2 3 4
Vocational Tech _____ Other _____

EMPLOYMENT: Present Employer _____ Job Title _____ Wages Wk _____
Length of Employment _____ If less than 5 years with present employer, list employers of past 5 years:

_____

_____

ACCIDENT: Date of Accident _____ Time _____ Place _____
Describe fully how accident happened _____

_____

Who did you report this accident to? _____ When? _____
Who witnessed the accident? _____
Who is your supervisor? _____

INJURY: Nature and location of injury (describe part(s) of body _____

_____

Name and Address of Doctor(s) _____
Who selected Your Doctor? _____ Date of First Visit _____
1st day unable to work? _____ Are you still under doctor's treatment'? _____

DISABILITY: How long does your doctor anticipate you will be off? _____
Are your wages continuing? _____ If so, from what source? _____
Regular wages, _____ Sick Leave, _____ Vacation _____
Have you ever collected compensation for a prior injury? ( ) yes ( ) no
If yes, give details _____
Have you ever had any other condition or injury involving this part of your body prior to this injury? ( ) yes ( ) no
If yes, give details _____

_____

Name and Address of Family Physician _____
I _____, received this day, a copy (front and back) of the Arkansas Workers' Compensation Form AR-N.

_____ _____
Employee Signature Date

_____ _____
Witness Witness

Use back for additional space.

FIRST REPORT OF INJURY OR ILLNESS--SUPERVISOR TO COMPLETE

EMPLOYER (NAME & ADDRESS INCL ZIP)

[redacted]

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS			

RATE PER:	DAY / WEEK	MONTH / OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES / NO
				DID SALARY CONTINUE?	YES / NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM / PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM / PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
			( ) CANNOT BE DETERMINED				

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES / NO		

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? / WERE THEY USED?	YES / NO YES / NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER