Mobile County
PUBLIC SCHOOLS

In the event of a job-related injury, the protocol below should be followed.

Immediate Supervisors/Principals

- ☐ Provide for the immediate first aid and safety of the injured employee.
- ☐ Call 9-1-1 if there's any possibility that the injury could be life-threatening.
- ☐ Give the injured employee a FULL On the Job Injury Packet.

Injured Employee

- ☐ Report the injury to your IMMEDIATE SUPERVISOR in writing within 24 hours. This can be done by email, text or on the On-the-Job Injury (OJI) Accident Form (HS-002). Failure to do this can result in not getting your days paid.
- ☐ Schedule and attend a doctor's appointment within 10 days of the accident to ensure that any missed days will be paid.
- ☐ The OJI Physician Statement (HS-004) must be completed by your physician and returned to Human Resources.
- ☐ Enter your OJI absence in Frontline for each day that you are out. This is your responsibility, not the responsibility of your Bookkeeper/Timekeeper. If you are unsure about how to do this, please reach out to your Bookkeeper/Timekeeper for instructions.
- ☐ ALL physician correspondence should be forwarded to Human Resources at oji@mcpss.com.
- ☐ Forward your portion of the OJI packet to Human Resources at oji@mcpss.com.

Immediate Supervisors/Principals

- ☐ Sign, then forward the accident report via fax/scan to Health Services (251-221-4298) and via email to Human Resources oji@mcpss.com.
- ☐ ALL physician notes should be forwarded to Human Resources at oji@mcpss.com.
- ☐ The injured employee MUST be cleared by Human Resources BEFORE they can return to work.
- ☐ When a service report is completed for payroll, a CODE-9 form will be sent to Human Resources reflecting the days that the employee was absent because of the OJI.
- ☐ **SEND THE SERVICE REPORT TO PAYROLL.**
- ☐ **DO NOT SEND THE CODE-9 FORM TO PAYROLL.**

Please refer to Board Policy 6.67 – JOB-RELATED INJURY for more information regarding the duties of the employee.
A copy of the Mobile County Public Schools Board Policy Book may be viewed at www.mcpss.com/hrforms.

Mobile County PUBLIC SCHOOLS

JOB RELATED INJURY PROCEDURE

IF AN ACCIDENT OCCURS

EMPLOYEE MUST CONTACT PRINCIPAL OR SUPERVISOR WITHIN 24 HOURS

PRINCIPAL OR SUPERVISOR will:

1. Provide for the immediate first aid and safety of the injured employee. If there is the possibility that the employee's injury is life threatening, the Emergency Number 911 should be called.
2. Complete Report of Injury/Accident Form (HS-002) for all accidents reported by employees acting within the line and scope of employment.
3. Send the original copy of all Form HS-002 to Health Services, a copy to Human Resources at oji@mcpss.com, and keep a copy for the school/department's records.
4. Give employee the Treatment Site Form HS-003, the Physician Statement Form HS-004, and the Release of Information Form HS-006 (these forms are to be used if the employee seeks treatment after work hours).

IF INJURY REQUIRES IMMEDIATE MEDICAL TREATMENT

1. Have employee sign Release of Information Form (HS-006).
2. The Supervisor/Principal or designee will email Report of Injury/Accident Form (HS-002) and Release of Information Form to Human Resources at oji@mcpss.com, then fax the forms to the Central Office Nurse at 221-4298 or call the Central Office Nurse at 221-4296.
3. Send employee to treatment site with Treatment Site Form and Physician Statement Form. *If employee has United Health Care Insurance, the employee must call his/her primary care Physician prior to treatment.*

AFTER EMPLOYEE IS TREATED:

1. Physician Statement Form **MUST** be provided to the Supervisor/Principal or the Central Office Nurse immediately after treatment in order to determine work status.
2. Should the employee seek medical care after work hours, he/she will take the Treatment Site Form and Physician Statement Form to the treatment site. The employee will notify his/her administrator of treatment at the beginning of the next work day.
3. The Employee must provide an additional Physician's Statement for each visit for the duration of the treatment at the beginning of the next work day via email to Human Resources at oji@mcpss.com.
4. The Central Office Nurse will contact treatment site if additional information is required related to this Injury.
5. Central Office Nurse will maintain all records related to the Job Related Injury in the employee's Health File in the Health Services Office and provide Human Resources with proper documentation.

IF EMPLOYEE IS TO MISS DAYS OF WORK:

1. The Central Office Nurse will be notified by the Principal/Administrator or designee and the documentation will be faxed to the Office Nurse.
2. For each payroll period the employee is off work, the school payroll clerk will email the Continuation of Pay Form (Code 9) to the Human Resources Department at oji@mcpss.com. ***Do not send Injury Report, Code 9 or medical documentation to payroll***. The school payroll clerk will note the days missed as Pay Code "OTJ-INJ" in Kronos daily. This will be reflected on the Service Report to be sent to the Payroll Department when time sheets are due for each payroll period.
3. The Employee **MUST** be cleared by the Employee Relations Department **PRIOR** to returning to work. An employee who returns to work without proper clearance from Employee Relations should be referred to HR immediately. The Supervisor/Principal may verify clearance by calling at 221-4542 or 4528.
4. Human Resources will send State board of Adjustment Packet to the Employee. Employees have one year from the date of the injury to apply for consideration of reimbursement for out of pocket expenses related to the injury by submitting an application to the Alabama State Board of Adjustments. These expenses include but are not limited to medical office visit payments, medications, mileage, supplies, etc. Contact Human Resources Employee Relations for an application.

Mobile County PUBLIC SCHOOLS

HS 002 (REV. 02/21)

MCPSS EMPLOYEE REPORT OF INJURY/ACCIDENT FORM

Complete this form immediately for all accidents reported by employees acting within the line and scope of employment. **Please submit completed form to oji@mcpss.com.**

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 Work: Years on Present Job _____	6. Telephone Number Home Alternate	7. Job Title Years Employed_____ _____Contract (Y/N)	8. Status ____Full Time ____Part Time/Sub
9. School/Department	10. Agency Address: **MOBILE COUNTY PUBLIC SCHOOL SYSTEM P O Box 180069 Mobile, AL 36618**		
11. Date of Injury / 12. Time of Injury	13. Date & Time Supervisor Notified	Did Employee continue to work at assigned tasks after accident ____Y ____N	
14. Is employee covered by medical insurance? _____Yes _____No If yes: _____Blue Cross/Blue Shield _____Other Insurance Name:_____	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/place where injured. School/Dept., Be specific, i.e, which classroom, office, where on grounds, etc.	

19. Did Employee seek medical treatment: Immediately During Work Hours After Work Hours

20. Describe fully what happened to cause the injury or illness.

21. Describe the injury or illness in detail and indicate the body part(s) affected:

22. 1 ST Aide/Treatment Employee received:

23. Were there any witnesses to the injury? _____Yes _____NO (If "yes", give name, address, and telephone number)

24.

Signature of Injured person	Print Name	Daytime Telephone Number	Date

25. INVESTIGATION OF THE ACCIDENT: TO BE FILLED OUT BY THE ADMINISTRATOR/SUPERVISOR **ONLY** (Attach additional sheets if needed) How did the accident happen? What was the employee doing?

Signature of Supervisor	Print Name	Daytime Telephone Number	Date

For Central Office Use Only : Employee Paid For: _____hrs/days Days Used _____ Date Returned to Work Full Status

LEAIR FORM 1 adapted for MCPSS

Mobile County PUBLIC SCHOOLS

HS-004

JOB-RELATED INJURY PROGRAM PHYSICIAN STATEMENT

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	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status ____Full Time ____Part Time ____Contract
9. Treating Physician	10. Agency Address: MOBILE COUNTY PUBLIC SCHOOL SYSTEM P O Box 180069 Mobile, AL 36618		
11. Date of Injury Date Treated	12. Is there a reasonable expectation that employee will be able to return to work _____Y _____N	13. If "yes" on item 12, give the date or approximate date of return	

Diagnosis and Probable Cause:

Was This Condition Present Prior To Injury? (circle) Yes No

Condition Is Related To: (circle) Employment Non-Job Accident Other

Treatment Ordered

Follow Up Treatment

14. If the employee can return to work, are there any restrictions on the employee's duties? YES NO

LIGHT DUTY RESTRICTIONS:

Lifting/Carrying	None Allowed	Maximum Pounds Allowed	_____
Standing, Sitting, Walking	None Allowed	Maximum Hours or % Allowed	_____
Bending, Stooping, Twisting	None Allowed	Maximum Hours or % Allowed	_____
Squatting, Kneeling	None Allowed	Maximum Hours or % Allowed	_____
Pushing, Pulling	None Allowed	Maximum Hours or % Allowed	_____
Climbing	None Allowed	Maximum Hours or % Allowed	_____
Reaching	None Allowed	Maximum Hours or % Allowed	_____
Use Of Upper Extremities	None Allowed	Maximum Hours or % Allowed	_____
Driving	None Allowed	Maximum Hours or % Allowed	_____
Environmental Exposure	Heat Cold Moisture	Maximum Hours or % Allowed	_____

Other:

Beginning Date _____ Until _____

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

16.

Signature of Attending Physician	Print Name	Telephone Number	Date

The need for the information in the physician's statement is authorized by our employee and your statements will be strictly confidential. Please email this Physician Statement the day of treatment to oji@mcpss.com. If email is unavailable, please fax this Physician Statement the day of treatment to 251-221-6237. If faxing is unavailable, please give this form to the patient to forward to the Employee Relations Supervisor. Please call the MCPSS Employee Relations Department at 251-221-4500 if you have any questions.

LEAPC FORM 1 adapted for MCPSS (rev 02/04/2021)

Mobile County
PUBLIC SCHOOLS

EMPLOYEE RELEASE OF MEDICAL INFORMATION FORM

TO WHOM IT MAY CONCERN:

I respectfully request and authorize my treating physician, his or her agents and employees and any other medical personnel to furnish to the Board of School Commissioners of Mobile County, its agents or employees, any and all medical reports, and other related information, in his/her or it's custody, possession or control related to any illnesses or injuries that I may have incurred or may incur while employed by the board of School Commissioners of Mobile County which I allege is a Job-Related Injury. I further authorize you, your agents and employees to discuss the contents of such records or reports or other related information and to provide orally, any additional information to be used in processing any Job-Related Injury claims now or in the future.

I hereby release the aforementioned physicians, medical personnel, Board of School Commissioners of Mobile County and any agents, servants and employees of the physicians, medical personnel, Board of School commissioners of Mobile County from any liability, loss and causes of action that may arise now or in the future as a direct or indirect result of or related to this request, and the release, receipt for use of any information that may be provided pursuant to this medical release.

I UNDERSTAND THAT THIS RELEASE DEALS WITH JOB-RELATED INJURIES ONLY.

_____ _____

DATE Employee Signature

_____

School/Department

_____

Witness

HB-OOJ

ATTENTION TREATMENT SITE:

DATE: _____

_____ is an employee of the Mobile County
(Name)
Public School System who is to be treated for a Job-Related Injury.

The Mobile County Public School System **DOES NOT** have Worker's Compensation. The employee must use his own insurance. Co-Payment requirement varies according to the type of insurance carried by the employee.

If the employee has no insurance, the employee is responsible for payment

If you have any questions, please contact the MCPSS Office Nurse at 221-4296.

Employee's Insurance Carrier
(Please check one of the following)

___ Blue Cross/Blue Shield (PEEHIP)
___ Blue Cross/Blue Shield
___ United Health Care
___ Prime Health
___ Southland
___ Other

Please fax the Physician's Statement to the Office Nurse at 221-4298
If **this is an Occupational Health Network Clinic, please see letter below.**

CORPORATE
IDENTIFICATION
CARD

Mobile Infirmary Medical Center
P.O. Box 2144 Mobile, Alabama 36652
(251) 431-5800

Occupational
Health
Network

Dear Treatment Site:

This letter is to identify the bearer as an employee of the *Mobile County Public School System,* a client of Occupational Health Network. This ktteI takes the place of the usual "corporate identification card". Thank you for your cooperation and please direct any questions you may have to me.

Sincerely,
Doug Daniel
Provider Liaison
Occupational Health Network

Attention School or Department: This form and the Physician's Statement Form are to be sent to the treatment site with the employee. **If the Employee has Complete Health, he/she must contact his/her Primary Care Physician Prior** to **Treatment.**

Mobile County PUBLIC SCHOOLS

DIVISION OF HUMAN RESOURCES
JOB-RELATED INJURY PAYROLL CODE 9 FORM

Please email this form to Employee Relations at oji@mcpss.com at the end of each attendance period if employee remains off work. Employee Relations will send to payroll for payment processing if approved.

Employee Name: _____

Title: _____

Employee Number: _____

Employing Dept/School: _____ Payroll Code 9

DATE OF INJURY:

In accordance with the agreed upon procedures of the Board Approved Pay-Continuation Procedure, a request is being submitted for continuation of pay during the pay period of _____ through _____ for the following:

Date	Hrs/ Runs	Date	Hrs/ Runs	Date	Hrs/ Runs	Date	Hrs/ Runs

TOTAL NUMBER OF DAYS _____ RUNS _____

Submitted by: _____
Administrator of School/Department

Validated by: _____
Office Nurse/Employee Health Program

Reviewed by: _____
Employee Assistance Supervisor

Authorized by: _____
Assistant Superintendent
Division of Human Resources

If you have any questions please call Employee Relations at 251-221-4528 or 251-221-4542.

cc: Employee
Payroll

JOB-RELATED INJURY

On-The-Job Injury Leave. On-the-job injury includes an accident or injury to an employee that occurs in the course of performing job duties for the Board or when the employee is directed or requested by the employer to be on the property of employer and which prevents the employee from working or returning to the job.

Employees who are accidentally injured on the job may be approved for paid "on- the-job injury" leave without using sick days, provided that:

a. The employee submits a signed written account of the accident to the principal or supervisor within twenty-four (24) hours after the injury occurred. The written account shall be attested by the principal or supervisor and forwarded immediately to the Superintendent's office. If the injured employee is not able to notify the Board, another person reasonably knowledgeable about the employee's condition and circumstances leading to the injury may provide the required notification.

b. The injured employee submits written medical certification from the attending licensed physician within ten (10) days of the injury, stating that the employee was injured and was unable to work or cannot return to work due to a specified injury, if there is a reasonable expectation that the employee will return to work and, if so, the expected date of that return. The Board may require a second opinion from a Board specified physician, at its expense.

Upon a determination that the employee has been injured on the job and cannot return to work, the Board may maintain the employee's salary and benefits for the period of incapacity caused by the injury, not to exceed ninety (90) days. An employee who is injured on the job may file a request for unreimbursed medical expenses and costs with the State Board of Adjustment. The Board will provide such reasonable assistance to the employee in filing the Board of Adjustment claim as is required by law, but assumes and will have no responsibility or liability for processing the claim or directly reimbursing the employee any unreimbursed medical expenses and costs. On-the-job injury leave will be administered in accordance with and subject to the requirements and limitations imposed by state law regarding such leave. The Board may require an employee who is returning from on-the-job injury leave to provide the Board with a healthcare provider's certification in form acceptable to the Superintendent in order to return to work.

Reference: Alabama Code - §16-1-18.1

Reference: Procedures: Job Related Injury

Public Hearings: February 11, 2015; February 19, 2015

Date(s) Amended: March 25, 2015, September 21, 2021