

Procedure: 4.9.9p. (III.U.10.a)

Workers' Compensation - Reporting an Accident

Revised: September 12, 2013; September 7, 2001

Last Reviewed: September 12, 2013

Adopted: April 2, 1987



I.PURPOSE:

The Technical College System of Georgia (TCSG) recognizes that efforts to return an employee to work following a work-related injury or illness benefits both the employee and the System Office or employing technical college. For this reason, the TCSG will work with employees within documented medical restrictions developed by their health care provider to facilitate a safe and timely return to the work force. The return could initially be in the form of a temporary, transitional duty assignment (i.e., modified duties) within established medical restrictions with the goal of a return to full, unrestricted duty.

The objectives of the return-to-work process include: permitting employees to resume productive employment as soon as possible following a job-related injury or illness; enabling the employee to gradually overcome any identified medical restrictions through a transitional period of modified duty; and, compliance with applicable provisions of the Americans With Disabilities Act (ADA), as amended, the Family and Medical Leave Act (FMLA), as amended and, applicable State Board policies and procedures.

The return-to-work process outlined in this procedure is not to be considered a recognition that an employee who is absent from work as a result of an on-the-job injury or illness is considered to be a qualified individual with a disability as defined by applicable provisions of the ADA, as amended. Any employee who believes that an illness or injury is of a permanent, progressive or chronic nature and/or impacts his/her ability to perform the essential functions of his/her job/position, should consult with staff in his/her office of human resources to determine the applicability of the ADA to his/her situation. Similarly, questions as to whether an absence is considered qualifying under the provisions of the FMLA should also be directed to the System Office or technical college office of human resources.

Further, the overall health and safety of all employees is of paramount importance to the TCSG. To this end, supervisors and managers should always be alert to any situation which could result in potential injury or illness to employees, students, contractors, and visitors to TCSG work sites and technical colleges. Employees are encouraged to bring any potentially unsafe or unhealthy working condition to the attention of their supervisor or reviewing manager for resolution.

All full- and part-time TCSG employees are eligible for Workers' Compensation benefits administered through the Georgia Department of Administrative Services' (DOAS) Risk Management Division, whether salaried, paid an hourly rate, or paid via "lump sum" (i.e., certain adjunct faculty members).

NOTE: Workers' Compensation coverage begins on an individual's first day of employment.

The formal return-to-work processes outlined in Paragraph VI.B., are generally designed for full- and part-time employees of salaried positions, i.e., those whose appointment has been designated as Regular or Regular, Part-time under applicable provisions of the Categories of Employment Procedure: 4.2.7p.

II. RELATED AUTHORITY:

O.C.G.A. § 20-4-11 – Powers of the Board
O.C.G.A. § 20-4-14 – TCSG Powers and Duties
Americans With Disabilities Act (ADA) of 1990
Americans With Disabilities Amendments Act (ADAAA) of 2008
29 C.F.R., Part 825, Family and Medical Leave Act, as amended
O.C.G.A. § 34-9-1 et seq. – Workers Compensation
Rehabilitation Act of 1973, as amended
TCSG Procedure: 4.1.4p. (Categories of Employment)
TCSG Procedure: 4.5.1p. (Family and Medical Leave Act)
TCSG Procedure: 4.6.2p. (Reasonable Accommodations in Employment)

III. APPLICABILITY:

All work units and technical colleges associated with the Technical College System of Georgia.

IV. DEFINITIONS:

Maximum Medical Improvement (MMI): a medical term indicating when a patient has attained a “recovery plateau” and no further progress is anticipated beyond the date indicated.

Modified/Restricted Duties: work assignments that are within identified medical restrictions prior to a MMI designation.

Restrictions: medical limitations prescribed by a physician or other health care provider that limits physical activities and daily life functions.

Return-to-Work Coordinator: the System Office or technical college human resources representative responsible for overseeing return-to-work activities for job-related and non-job-related injuries and illnesses. The coordinator also serves as the primary point of contact with the DOAS Risk Management Division for workers’ compensation matters.

Transitional Duty: a temporary situation when an employee returns to work from a personal or occupational injury or illness to medically restricted or modified duties for a specified period of time as determined through a transitional employment plan.

Transitional Employment Plan: documentation of the duties and responsibilities an employee will perform during the established transitional period.

Serious Health Condition: an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility (i.e., inpatient care), or continuing treatment by a health care provider for a condition that prevents an employee from performing the functions of his/her job or prevents a qualified family member from participating in school or other daily activities. Subject to certain conditions, the term continuing treatment includes an incapacity of more than three (3) consecutive, full calendar days and two (2) visits to a health care provider within thirty (30) days of the first day of incapacity or one (1) visit to a health care provider and a continuing regimen of care; an

incapacity caused by pregnancy or prenatal visits; a chronic condition or permanent or long-term conditions; or, absences due to multiple treatments.

Work-Related Injury or Illness: any injury or illness arising out of and in the course of employment is a compensable work-related claim. If an employee is injured while performing assigned duties and responsibilities during assigned work hours, he/she is covered under the Workers' Compensation program. NOTE: injuries sustained while an employee engages in unassigned duties or during personal activities, breaks, or lunch periods may not be covered. Additionally, injuries that occur during an employee's normal commute to and from work, as well as those resulting from an employee's willful misconduct are not covered.

Workers' Compensation Program: pursuant to applicable statutes, the medical, rehabilitation and income benefits program administered by the Georgia Department of Administrative Services' Risk Management Division for state employees.

V. ATTACHMENTS:

- Attachment: 4.9.9p.a1. DOAS Employee's Report of Injury Form
- Attachment: 4.9.9p.a2. DOAS Supervisor's Accident Investigation Form
- Attachment: 4.9.9p.a3. DOAS Telephonic Reporting Instructions
- Attachment: 4.9.9p.a4. DOAS Georgia Activity Analysis Form
- Attachment: 4.9.9p.a5. TCSG Incident Report
- Attachment: 4.9.9p.a6. Transitional Employment Plan
- Attachment: 4.9.9p.a7. Essential and Marginal Job Function Analysis Worksheet
- Attachment: 4.9.9p.a8. Transitional Employment Tracking Form
- Attachment: 4.9.9p.a9. DOAS Leave Election Form

VI. PROCEDURE:

A. Occupational Injury or Illness:

1. When a work-related illness or injury occurs, all medical care/treatment must be delivered by a health care provider or urgent/primary care medical clinic associated with First Health Network administered by AmeriSys, (a Georgia Department of Administrative Services' certified Workers' Compensation/ Managed Care Organization). The only exception to this provision is for a medical emergency referenced in Paragraph VI.A.3. With respect to a medical emergency, all follow up medical care/treatment must be coordinated through AmeriSys as provided in Paragraph VI.A.3. NOTE: An employee's failure to comply with this requirement may result in the non-payment of the cost of his/her care/treatment by the Georgia Department of Administrative Services' (DOAS) Risk Management Division.
2. An employee injured on the job or who suffers a work-related illness should notify his/her supervisor of the injury/illness. In the absence of his/her supervisor, the employee should provide notice of the injury/illness to the System Office or technical college human resources representative responsible for managing workers' compensation matters or other available human resources staff member. The employee should also provide the System Office or technical college office of human resources with a completed Employee's Report of Injury Form (Attachment: 4.9.9p.a1.). Unless dictated by the employee's medical condition, both formal notice and the completed form should be provided no later than twenty-four (24) hours following the injury or illness. Additionally, the employee's supervisor should gather the facts surrounding the

injury or illness and complete a Supervisor's Accident Investigation Form (Attachment: 4.9.9p.a2.) as soon as possible after the accident/incident.

3. In the event of a medical emergency, 911 should be called or the employee should be immediately transported to the nearest emergency medical care facility/hospital. Following emergency treatment, a human resources representative or other designated System Office or technical college official should contact the DOAS call center at 1-877-656-7475 to report the injury. The information referenced in Attachment: 4.9.9p.a3.(Telephonic Reporting Instructions) should be gathered and provided to the DOAS call center representative. If the employee needs further care/treatment, he/she should contact AmeriSys at 678-781-2848 or 1-800-900-1582 and a nurse case manager will assist the employee with locating a physician or an affiliated First Health Network managed care facility such as an urgent care/primary care medical clinic/center to provide these services.
4. In a non-emergency situation, the employee's immediate supervisor, a human resources representative or other designated System Office or technical college official should first contact the DOAS call center to report the injury/illness as outlined in Paragraph VI.A.3. Also as referenced in Paragraph VI.A.3., the employee should call AmeriSys and a nurse case manager will assist the employee with finding a health care provider or an affiliated managed care facility to provide needed medical services/treatment. If appropriate given the nature of the injury/illness, the employee may transport himself/herself (for treatment) or may elect to contact a friend or relative for transportation.
5. If a non-emergency injury or illness requires medical attention and transportation is not available or the employee is unable to transport himself/herself, the employee should be transported by a System Office or technical college representative to the health care provider or urgent care/primary care medical clinic/center authorized by AmeriSys. NOTE: The driver must possess a valid driver's license.
6. As provided in Paragraph VI.A.4. and, as applicable Paragraph VI.A.3., transportation should be provided using a State vehicle, if available. If a State vehicle is not available, the System Office or technical college staff member may use his/her personal vehicle to transport the employee. In these circumstances, the staff member may be reimbursed for mileage, parking fees and, as applicable, other related, reimbursable expenses.
7. Any personal vehicle used for the purpose of transporting an employee for medical treatment as provided in Paragraph VI.A.5 must be insured for loss as the State of Georgia does not insure private vehicles, even when (the vehicle) is used in the performance of State business.
8. If the employee is not released to immediately return to work, he/she will not be charged leave for the day of the injury/illness.
9. As applicable, the employee's immediate supervisor and/or the designated human resources representative should contact the employee the next business day to check on his/her progress and well-being.
10. If an injured employee is not released to return work after the initial appointment, but requires one or more follow-up appointments, the treating health care provider should be

provided a copy of the completed Georgia Activity Analysis Form (Attachment: 4.9.9p.a4.) prior to or at the time of the next scheduled appointment. The Georgia Activity Form is brief description of the functions and physical, cognitive and environmental demands of the employee's position and is derived from a completed Essential and Marginal Job Function Analysis Worksheet (Attachment: 4.9.9p.a7.). The Georgia Activity Form is designed for use by the treating health care provider in determining whether the employee may return to full, unrestricted duty or, instead, can (at some point during the period of absence) return with modified/restricted duties based on his/her medical condition.

11. If an employee is dissatisfied with the health care provider or managed care facility initially selected, he/she may make a second selection from the list of available AmeriSys providers without permission. Any further change of providers first requires permission from the AmeriSys nurse case manager and DOAS.
12. If an injury or illness does not require medical treatment and does not result in an absence from work, the employee's supervisor, or a human resources representative or other designated official should complete Attachment:4.9.9p.a5. (TCSG Incident Report). The form should be maintained in the System Office/technical college Workers' Compensation file in a locked compartment and should be managed in a confidential manner with limited access. Should the employee later require medical care/treatment and/or is later absent from work as a result of the injury or illness, a Worker's Compensation report should be initiated as provided in Paragraph VI.A.4.
13. A full- or part-time salaried employee who is absent from work for more than seven (7) scheduled work days after sustaining a work-related injury or illness may elect to receive worker's compensation income benefits (beginning on the eighth day of the absence) or, instead, use his/her accrued sick or annual leave, personal leave or, as applicable, Fair Labor Standards Act (FLSA) Compensatory Time to remain in full pay status in lieu of receiving workers' compensation income benefits. The employee's decision should be made using a Leave Election Form (Attachment 4.9.9p.a9.) which will, in turn, be submitted to the DOAS Risk Management Division. NOTE: An employee electing to receive workers' compensation income benefits will be paid for the first seven (7) days of the absence only if he/she is unable to work for more than twenty-one (21) consecutive days.
14. A full- or part-time salaried employee who is absent from work for less than seven (7) scheduled work days after sustaining a work-related injury or illness must use his/her accrued sick or annual leave, personal leave or, as applicable, FLSA Compensatory Time or forfeited leave to remain in pay status for the duration of the absence.
15. In instances in which an absence for a work-related injury or illness is determined to be a serious health condition as defined by applicable provisions of the Family and Medical Leave Act (FMLA), the period of absence will be designated as family leave and will be credited against the employee's twelve (12) week family leave entitlement as provided in TCSG Procedure 4.5.1p. and the parameters outlined in Paragraph VI.B.3. of this procedure. NOTE: this designation is permissible whether the employee elects to receive workers' compensation income benefits, utilizes available leave (to include FLSA Compensatory Time) to remain in pay status or, elects or subsequently transitions to a family leave without pay status when all available paid leave is exhausted.

16. In instances in which an employee remains unable to return-to-work after all his/her family leave entitlement has been exhausted and the employee has elected not to use the paid leave options referenced in Paragraph VI.A.14 or all categories of paid leave were used but have been exhausted, he/she must make a written request for a leave of absence without pay to continue his/her employment with the System Office or employing technical college. The Commissioner, technical college president, or his/her designee may, in turn, authorize placement on a short-term leave of absence without pay (where appropriate) or, for a longer projected period of absence, a contingent leave of absence without pay.

B. Return-to-Work Following an Occupational Injury or Illness:

1. If the treating health care provider determines that an employee can immediately return to work following a job-related injury or illness without restrictions, the employee should first provide the physician's written release to his/her supervisor. In turn, the supervisor will coordinate the employee's return-to-work date with the System Office or technical college Return-to-Work Coordinator. The Return-to-Work Coordinator will communicate this information to Risk Management Division of DOAS.
2. Alternatively if, at some point during an employee's absence, he/she is released to return-to-work with restrictions, the employees' supervisor and the Return-to-Work Coordinator will review the restrictions outlined by the treating health care provider and make a determination as to whether the System Office or technical college can provide transitional (i.e., modified) duties or other associated position modifications (e.g., a reduced work schedule) for the employee for the referenced time period. The identified transitional duties and/or other position modifications must meet the operational and staffing needs of the System Office or technical college and fully accommodate the identified medical restrictions. NOTE: as applicable, the provisions of the Reasonable Accommodations in Employment Procedure: 4.6.2p. regarding qualified individuals with a disability should be considered when making these determinations.
3. As referenced in Paragraph VI.A.15., when a work-related injury or illness is also determined to be a serious health condition as defined in the FMLA and the employee meets established FMLA eligibility requirements, all or a portion of the projected period of absence will be designated as family leave as determined by the amount of family leave that the employee has available within his/her twelve (12) week entitlement. In these instances, the employee must be provided proper notice and timely written notification of this decision as stipulated in the TCSG Family Leave Procedure: 4.5.1p.
4. If, during the absence period, the treating health care provider certifies that the employee on family leave is able to return to work with restrictions, the System Office or employing technical college may initiate the return-to-work process. While on authorized family leave, an employee is permitted to voluntarily accept a transitional duty assignment but may not be required to do so. Instead, the employee may elect to remain on family leave through the period authorized by his/her treating health care provider or until his/her twelve (12) week family leave entitlement is exhausted, whichever occurs first. NOTE: if an employee receiving workers' compensation income benefits is offered but does not accept an available transitional duty assignment authorized by his treating health care provider, the Risk Management Division of DOAS will be notified. As a result,

the employee's income benefits may be impacted as stipulated in O.C.G.A. § 34-9-240 and applicable regulations of the Risk Management Division of DOAS

5. Given the considerations outlined in Paragraph VI.C.4., the Return-to-Work Coordinator will schedule an initial meeting with the employee and his/her supervisor to discuss the identified medical restrictions in conjunction with the ability of the System Office or technical college to develop a temporary transitional employment plan to facilitate the employee's return-to-work. If a return to a transitional duty assignment in the employee's pre-injury position or another position in his/her assigned work unit is not possible, the Return-to-Work Coordinator will review other potential temporary assignments within the System Office or technical college. The Coordinator should use the information reflected in Attachment: 4.9.9p.a7. (Essential and Marginal Job Function Analysis Worksheet) in his/her analysis.
6. If a return to work in a transitional duty assignment cannot be authorized, the Return-to-Work Coordinator will communicate this decision to the employee in writing and subsequently notify the Risk Management Division of DOAS.
7. If a transitional duty assignment can be authorized and after consultation with the employee's supervisor, the Return-to-Work Coordinator should complete Attachment: 4.9.9p.a6. (Transitional Employment Plan) which includes: the basis for the plan; the start and end dates of transitional duties; the specific duties to be performed; the next review date; and, signatures from both the employee and his/her supervisor. The plan should then be forwarded to the treating health care provider for approval before implementation.
8. During the transitional period, the Return-to-Work Coordinator will meet regularly with the employee to evaluate his/her progress and discuss any concerns the employee may have. The Transitional Employment Tracking Form (Attachment: 4.9.9p.a.8.) should be used to document the employee's progress while performing the transitional duties. These duties may be modified should the employee demonstrate improvement in his/her physical capabilities or, alternatively, regression. Any modifications to the plan must be reviewed and approved by the treating health care provider.
9. Transitional duty assignments for work-related injuries or illnesses are generally designed to encompass a period not to exceed forty-five (45) calendar days. At the conclusion of this time period, the employee will be expected return to his/her pre-injury position and perform all assigned duties and responsibilities provided written authorization is received from his/her treating health care provider.
10. If the treating health care provider determines that the employee is unable to assume regular duties and perform the essential functions of his/her pre-injury position after the forty-five (45) day period referenced in Paragraph VI.C.9. or there are documented, long-term medical restrictions present (e.g. an MMI designation - Maximum Medical Improvement), applicable provisions of the Americans With Disabilities Act, as amended and State Board policies and TCSG procedures (e.g., FMLA, Reasonable Accommodations in Employment, etc.) will be utilized to determine available options (for the employee) to include his/her suitability for continued employment.

VII. RECORD RETENTION:

- A. All documents associated with a Workers' Compensation claim should be maintained in a separate Workers' Compensation file in a locked compartment. The materials should be managed in a confidential manner with limited access and retained for a period of five (5) years or until settlement of any associated claim(s).
- B. All medically-related documents associated with an employee's personal injury or illness should be maintained in an employee's medical file.



Attachment: 4.9.9p.a1.

Employee's Report of Injury

Employee Name (Please Print): _____

Date of Birth: ___/___/___ Sex: ___ Male ___ Female Cell #: _____

Home Address: _____
Street/P.O. Box

City: _____ State: _____ Zip Code: _____

Job Title: _____ How Long Employed: _____

Social Security Number: ___-___-___ Monthly Salary or Hourly Rate of Pay: _____

Location of Accident: _____
System Office/Technical College Campus Area (office/bathroom/etc.)

Date of Accident: _____ Time of Accident: _____

Describe how the accident occurred (including events immediately preceding the accident): _____

Describe bodily injury sustained (please be specific about the body part(s) affected): _____

As applicable, recommendations on how to prevent this accident from reoccurring: _____

Name of Supervisor: _____ Work Phone #: _____

Name(s) of Witness(es): _____ Work Phone #: _____
_____ Work Phone #: _____

Date Accident Reported to Supervisor: _____

Date Accident Reported to Office of Human Resources: _____

Do you Require Medical Attention? ___ Yes ___ No

If you have already received treatment for the injury, please provide the name of the treating health care provider and his/her phone number: _____

Signature of Employee: _____ Date: _____

Georgia Department of Administrative Services
 Risk Management Services Division
 200 Piedmont Ave SE, Suite 1208 West
 Atlanta, Georgia 30334

SUPERVISOR'S ACCIDENT INVESTIGATION

| | | |
|--|---|-----------------------------|
| Location where accident occurred | Employer's Premises Yes <input type="checkbox"/> No <input type="checkbox"/> Job Site Yes <input type="checkbox"/> No <input type="checkbox"/> | Date of accident or illness |
| Who was injured? | | Time of Accident |
| Date Employed | Job Title | Department |
| Property/Equipment Damaged | | |
| What was the employee doing when the injury/illness occurred? What machine or tool was being used? What type of operation? | | |
| How did the injury/illness occur? List all objects and substances involved. | | |
| Part of body affected/injured? | Any prior physical conditions? If so, what? | |
| Nature and extent of injury/illnesses and property damaged (be specific) | | |

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY/ILLNESSES:

- | | | |
|----------------------------|-------------------------------------|-------------------------------------|
| Failure to Lockout _____ | Improper maintenance _____ | Poor housekeeping _____ |
| Failure to Secure _____ | Improper protective equipment _____ | Poor ventilation _____ |
| Horseplay _____ | Inoperative safety device _____ | Unsafe arrangement or process _____ |
| Improper dress _____ | Lack of training or skill _____ | Unsafe equipment _____ |
| Improper guarding _____ | Operating without authority _____ | Unsafe position _____ |
| Improper Instruction _____ | Physical or mental impairment _____ | Other _____ |
| | | _____ |

Supervisor's corrective action to ensure this type of accident does not recur:

| |
|--|
| |
| |

Was the employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? _____

Was the employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? _____

Did the employee promptly report the injury/illness? _____

Is there modified duty available? _____

| | | | |
|--|--|--|--|
| | | | |
|--|--|--|--|

Supervisor's Name

Signature

Date

Phone Number



Attachment: 4.9.9p.a3.

**Telephonic Reporting Instructions
Occupational Injuries and Illnesses**

**DOAS Call Center
Call Toll Free 1-877-656-7475
24 hours a Day/7 Days a Week**

NOTE: Claims can only be reported by a Human Resources Representative, Supervisor, or Other Designated College Official.

As soon as possible following an accident, contact the DOAS Call Center with the following information:

- Name and Address of Injured Employee
- Name, Address and Telephone Number of the System Office/Technical College
- Social Security Number of Injured Employee
- Age and Sex of Injured Employee
- Date and Time of Accident
- Description of Accident (How, Where, Why)
- Type of Injury (Cut, Scrape, Burn, etc.)
- Exact Part of Body Injured
- Hourly/Weekly/Monthly Wage
- As Applicable, Name and Address of Physician/Hospital
- Has Injured Employee Returned to Work?

Injuries should be reported to the DOAS Call Center within 24 hours of the accident. Reporting should be delayed only long enough to ensure that an employee has been transported or has transported himself/herself to a health care provider or managed care facility for treatment.

After a claim has been initially reported to the DOAS Call Center, any subsequent correction should be made by contacting TCSG's dedicated DOAS Workers' Compensation Claim Specialist. A copy of the completed first report of injury (Form WC-1) will be faxed to both the System Office or employing technical college and the DOAS Workers' Compensation Claim Specialist as soon as possible after the report is filed.

NOTE: only injuries requiring medical care or lost work time should be reported to the DOAS call center. Injuries requiring only first aid or requiring no medical care should be reported on the TCSG Incident Notice.

Attachment: 4.9.9p.a4. Georgia Activity Analysis

| | |
|---|-------------------------|
| POSITION TITLE: | EMPLOYEE NAME: |
| DATE/BY WHOM: | AGENCY/LOCATION: |
| I. PURPOSE OF POSITION (Describe in terms of the reason the position exists.) | |
| | |
| II. TASKS | |
| A. Describe each task, in order of frequency performed. What is required to do the position? B. Indicate primary physical, mental and environmental demands required to perform each task. | |
| A. Tasks | B. Demands |
| | |
| | |
| | |
| | |
| | |
| | |
| III. REQUIRED PRODUCTIVITY (Describe production rate including quantity & quality of work required) | |
| | |
| IV. WORK SCHEDULE REQUIREMENTS (Describe specific shifts (including rotating) and/or hours, travel or overtime) | |
| | |
| PHYSICIAN COMMENTS (Complete the appropriate box below and provide comments as necessary) | |
| ➤I release _____ to this job as above described. | |
| ➤I release _____ to this job under the following conditions: | |
| | |
| The medical rationale is: | |
| | |
| ➤I cannot release _____ to any part of this job at this time. The medical rationale is: | |
| | |
| Next appointment is scheduled for | |
| Physician's Signature: | Date: |



Attachment: 4.9.9p.a5.

Incident Report

Instructions: This form should be completed by an employee's supervisor or System Office or technical college human resources representative only if an employee's injury or illness does not require medical attention/treatment or does not result in an absence from work. If an injury or illness does require medical attention/treatment, a System Office or technical college human resources representative or other designated official should contact AmeriSys at 678-781-2848 or 1-800-900-1582 as provided in the TCSG Procedure governing Workers' Compensation and Return-to-Work Program.



Date Employee Reported Incident: _____

Date of Incident: _____

Time of Incident: _____

Name of Injured Employee: _____

Employee ID#: _____

Job Title: _____

Description of Incident: _____

Type of Injury: _____

Location Where Injury Occurred: _____

Was First Aid Administered: Yes No

If Yes, what type? _____

Were There Any Witnesses Present? Yes No

If Yes, please provide name(s) and contact information: _____

Supervisor's Name: _____ Telephone #: _____

Individual Completing Report: _____ Telephone #: _____

Date Report Completed: _____

NOTE: This form does not replace WC-1, Employer's First Report of Injury



Attachment: 4.9.9p.a6.

Transitional Employment Plan

Employee Name (Please Print): _____

Job Title: _____

System Office/Technical Office Work Unit: _____

Physical Capacities/Restrictions Recommended by Health Care Provider: _____

Date Restrictions Began: _____

Next Review Date: _____

Plan Specifications

State Date: _____

End Date: _____

Describe Job and/or Specific Tasks to Performed: _____

As Applicable, Describe Modified Work Schedule (hours per day and days per week): _____

If Applicable, Describe Projected Modifications to Initial Work Schedule as Recommended by Health Care Provider and Potential Date of Such Modifications: _____

Special Considerations: _____

Acknowledgements

The Transitional Employment Plan has been reviewed and discussed with me to clarify any questions I may have. I have been provided with a copy of the Plan and understand that should I experience any difficulties while performing the transitional duties, I will immediately contact my supervisor.

Employee's Signature: _____ Date: _____

We have reviewed and discussed the Transitional Employment Plan with the employee and have provided him/her with a copy of the Plan.

Return to Work Coordinator's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Health Care Provider Authorization

I have reviewed and approved the Transitional Employment Plan.

Health Care Provider's Signature: _____ Date: _____

OR

I will not authorize the Transitional Employment Plan for the following reasons: _____

Health Care Provider's Signature: _____ Date: _____

Attachment: 4.9.9p.a7.

TECHNICAL COLLEGE SYSTEM OF GEORGIA
Essential and Marginal Job Function Analysis Worksheet

SECTION I: Guidelines for Determining Essential versus Marginal Functions

Under applicable provisions of the Americans with Disabilities Act (ADA), as amended, covered employers are required to complete an essential function analysis when a disability accommodation request is made. All TCSG System Office work units and all associated technical colleges are encouraged to complete the analysis prior to advertising a vacant position and to use the information in the interviewing process, as appropriate.

Job descriptions should include references to essential job/position functions and this information is applicable to staff training and development activities as well as with the performance appraisal/evaluation processes.

Pursuant to ADA guidelines, employment decisions are to be based on the essential functions of a particular job/position. Other functions categorized as marginal or secondary are not to be used as the basis for an employment decision. Unlike an essential job/position function, a marginal function is relatively incidental to the reason the position exists. Also, unlike an essential function, a marginal function can be transferred to another position without causing an undue hardship to the work unit. Although the task must be accomplished, it can be carried out by another employee.

Used properly, the Worksheet is an effective tool to ensure the accurate identification of both essential and marginal functions, the percentage of time required to perform job-related physical activities, the physical and cognitive requirements of the job/position, the equipment used, if any, and the accompanying environmental surroundings.

SECTION II: Job/Position Information

Position #: _____ Position Title: _____

Job Code#: _____ Work Unit: _____

Incumbent Name (if applicable): _____

SECTION III: Position Summary

Provide a brief position summary which describes the purpose of the position (please attach additional page(s) if needed):

For Sections IV, V, VI, please assess and indicate whether each identified category/statement is either “Essential” (E), “Marginal” (M), or “Not Applicable” (N/A).

SECTION IV: Cognitive Processes

 E M N/A

- 1. Is the inspection of products, objects or materials necessary? _____
- 2. Does the job require analyzing information, documents, or data? _____
- 3. Does the job require planning sequences of operations or actions?
 - a. Simple Planning _____
 - b. Complex Planning _____
- 4. Does the job require decision-making skills?
 - a. Simple Decisions _____
 - b. Complex Decisions _____
- 5. Is logic required to define problems, collect information, and establish facts? draw accurate conclusions, interpret information and/or deal with abstract variables? _____
- 6. Are basic counting, addition and/or subtraction required? _____
- 7. Is performing algebra, geometry, and/or statistics necessary?
 - a. Simple calculations _____
 - b. Complex calculations _____
- 8. Is the ability to comprehend written language required?
 - a. Basic instructions, safety rules, correspondence _____
 - b. Technical or professional materials, financial or legal documents _____
- 9. Is the ability to write necessary?
 - a. Compose letters or memoranda _____
 - b. Compose and/or edit reports or other professional materials _____
- 10. Is the ability to comprehend verbal instructions a necessary part of the job?
 - a. Comprehend simple verbal instructions _____
 - b. Comprehend technical and/or complex verbal instructions _____
- 11. Is verbal communication a necessary part of the job?
 - a. Is talking in standard English required? _____
 - b. Is talking using complex, technical or professional English required? _____
 - c. Is knowing a foreign language required? Is so, please identify the foreign language: _____

Comments:

SECTION V: Position Components
(Assessment of the responsibilities and required aptitudes)

E M N/A

1. Work with frustrating situations: Job objectives are often hindered by events beyond the incumbent's control. _____
2. Job is a high demand position with associated stress _____
3. Advising required: counsel, recommend, guide or caution others in legal, financial, scientific, technical, educational, or other professional matters _____
4. Coordinate, monitor, and organize the activities of others to achieve desired objectives, without possessing supervisory authority _____
5. Teaching/training others or providing academic instruction _____
6. Participate in group activities requiring interpersonal skills and cooperation _____
7. Working under time pressures and established deadlines _____
8. Working an irregular schedule. May be required to work additional hours _____
9. Must manage multiple assignments with conflicting demands or priorities _____
10. Concentration: maintain attention to detail over extended period(s) of time. Must be continually aware of variations to changing situations_ _____
11. Frequent travel is a job requirement _____
12. Reaction or response: quick reaction or immediate response to emergencies _____
13. Research and analysis: fact-finding, interpretation, and investigation required In preparing reports, documents, or evaluations _____
14. Accountability and consequence of error: responsible for money, equipment or personnel. If work objectives are not met, serious consequences may result _____
15. Work is performed independently or with minimal on-site supervision _____
16. Supervise others: recruit, screen, assign and monitor work products, train and evaluate other employees _____
17. Confidentiality: works with confidential information, material, or records _____

Comments:

SECTION VI: Physical Requirements

E M N/A

- 1. Is talking necessary? _____
- 2. Is hearing necessary? _____
- 3. Is sight necessary? (If Not Applicable, skip to 3.e.)
 - a. Is the ability to distinguish between colors necessary? _____
 - b. Is vision clarity of greater than 20 feet necessary? _____
 - c. Is vision clarity of less than 3 feet necessary? _____
 - d. Is depth perception necessary? _____
 - e. Is an entire field of vision/periphery required? _____
- 4. Is walking necessary? (If Not Applicable, skip to question #5)
 - a. Is walking on ramps a regular duty assignment? _____
 - b. Is walking distances of a mile or less daily a regular duty assignment? _____
- 5. Is sitting a part of the job? (If Not Applicable, skip to question #6)
 - a. 0-2 hours per day _____
 - b. 2-4 hours per day _____
 - c. 4-8 hours per day _____
- 6. Is standing a part of the job? (If Not Applicable, skip to question #7)
 - a. 0-2 hours per day _____
 - b. 2-4 hours per day _____
 - c. 4-8 hours per day _____
- 7. Is a certain amount of dexterity required? (If Not Applicable, skip to Question #8)
 - a. Is good balance required? _____
 - b. Must the employee possess the ability to grip, hold and turn an object in his/her hands? _____
 - c. Does the job require a "pinch" type activity using one's fingers? _____
- 8. Is climbing ladders and/or stairs a job requirement? (If Not Applicable, skip to Question #9)
 - a. Will climbing involve carrying object(s) of greater than 10 lbs.? _____
 - b. Will climbing frequency be 25 or more times per day? _____
- 9. Does the job require the lifting of objects? (If Not Applicable, skip to Question #10)
 - a. Lifting 10 - 24 lbs. _____
 - b. Lifting 25 - 49 lbs. _____
 - c. Lifting greater than 50 lbs. _____
 - d. Is lifting a frequent task? _____
 - e. Is lifting an infrequent task? _____
- 10. Is pushing or pulling objects required? (If Not Applicable, skip to Question #11)
 - a. Is pushing or pulling objects a frequent task? _____
 - b. Is pushing or pulling objects an infrequent task? _____
- 11. Does the position require repetitive motion – excessive repeating movement of hands, wrist and arms? _____
- 12. Is stooping, kneeling, or crouching required? (If Not Applicable, skip to to Question #13)
 - a. Is stooping, kneeling, or crouching a frequent task? _____
 - b. Is stooping, kneeling, or crouching an infrequent task? _____
- 13. Is crawling (i.e., to crawl and move about on hands and knees) required? _____

Comments:

Physical Requirements – Definitions:

Talking: communicate verbally, converse with, convey, express oneself, exchange information.

Hearing: perceive the nature of sounds by ear.

Seeing/Sight: detect, identify, perceive with the eyes, to observe.

Walking: moving about on foot to accomplish tasks, moving from one work site to another

Sitting: remain in a seated position.

Standing: remaining on one's feet in an upright position without moving about.

Balance: maintaining body equilibrium to prevent falling when walking, standing, crouching, kneeling, running, etc., on surfaces which may be slippery, narrow, of changing elevations, of different conditions, etc.

Fingering: picking, pinching, typing or otherwise working primarily with fingers rather than with the whole arm or hand. To grip or hold an object in one's hand(s).

Climbing: ascending or descending ladders, stairs, scaffolding, ramps, poles using feet and legs and/or hands and arms. This factor is important if the amount and kind of climbing required exceeds that required for ordinary locomotion.

Lifting: raising objects from a lower position to a higher position or moving objects horizontally from position to position. This factor is important if it occurs to a considerable degree and requires the substantial use of the upper extremities and back muscles.

Pushing: to exert force against an object; uses upper extremities to press against something with steady force (i.e., to thrust forward, downward, or outward) to move the object away from the force.

Pulling: using upper extremities to exert force in order to draw, drag, haul or tug objects in a sustained motion.

Stooping: bending body downward and forward by bending spine at the waist. This factor is important if it occurs to a considerable degree and requires the full use of the lower extremities and back muscles.

Crouching: bending the body downward and forward by bending leg and spine.

Crawling: moving about on hands and knees or hands and feet.

Kneeling: bending legs at knee to come to a rest on knee or knees.

SECTION VII: Degree of Physical Activity – Indicate the percentage of time engaged in pushing and pulling activities. The total should equal 100%

| | | N/A | <25% | 25-49% | 50-74% | >75% |
|------------|--|-----|------|--------|--------|------|
| Sedentary | Exert up to 10 lbs. of force occasionally* or a minute amount frequently** | ___ | ___ | ___ | ___ | ___ |
| Light | Exert up to 20 lbs. of force occasionally and/or up to 10 lbs. of force frequently | ___ | ___ | ___ | ___ | ___ |
| Medium | Exert 20-50 lbs. of force occasionally and/or 10-15 lbs. of force frequently | ___ | ___ | ___ | ___ | ___ |
| Heavy | Exert 50-100 lbs. of force occasionally and/or 25-50 lbs. of force frequently | ___ | ___ | ___ | ___ | ___ |
| Very Heavy | Exert 100 lbs. of force occasionally and/or 50 lbs. of force frequently | ___ | ___ | ___ | ___ | ___ |

NOTE: *Occasionally: activity or conditions exist up to 1/3 of the time

****Frequently:** activity or conditions exist from 1/3 to 2/3's of the time

Comments:

SECTION VIII: Physical Surroundings and Hazards – indicate which statements are applicable:

- _____ Spends 0-2 hours per day outdoors
- _____ Spends 2-4 hours per day outdoors
- _____ Spends 4-8 hours per day outdoors
- _____ Works in temperatures at or below 32 degrees for more than one hour at a time
- _____ Works in temperatures at or above 90 degrees for more than one hour at a time
- _____ Does noise require an employee to shout in order to be heard
- _____ Is there exposure to vibrating movements to the extremities or the entire body
- _____ Is there a risk to bodily injury due to the proximity to mechanical parts, motorized equipment, instruments, electric currents, or chemicals
- _____ Are there conditions that may affect the respiratory system, skin, or allergies (e.g., fumes, odors, air particles)

Comments:

SECTION IX: Equipment, Tools, Electronic and Communication Devices – List those the employee will use to perform his/her assigned duties

- 1 _____
- 2 _____
- 3 _____
- 4 _____

- 5 _____
- 6 _____
- 7 _____
- 8 _____

Comments:

SECTION X: Essential and Marginal Function Statements – A job function statement should focus on the purpose (of the job), the result(s) to be accomplished, and the productivity required rather than the manner in which the function is performed. Identify whether the functions are essential or marginal and provide the projected percentage of time devoted to each in a normal work day. Please start each statement with a verb. NOTE: the Essential and Marginal Functions should total 100%

| Essential (Primary) Functions | % | Marginal (Secondary) Functions | % |
|-------------------------------|---|--------------------------------|---|
| 1. _____ | | _____ | |
| 2. _____ | | _____ | |
| 3. _____ | | _____ | |
| 4. _____ | | _____ | |
| 5. _____ | | _____ | |
| 6. _____ | | _____ | |
| 7. _____ | | _____ | |
| 8. _____ | | _____ | |
| 9. _____ | | _____ | |
| 10. _____ | | _____ | |
| 11. _____ | | _____ | |
| 12. _____ | | _____ | |
| 13. _____ | | _____ | |
| 14. _____ | | _____ | |
| 15. _____ | | _____ | |

Comments:

SECTION XI: General Information:

Must a vehicle be driven to perform the essential/primary functions of the position ? ___ Yes ___ NO

Location(s) where the work is performed: _____

Assigned work schedule: _____

Name of Immediate Supervisor: _____

Name and Title of Individual Completing this Worksheet: _____

Date: _____

Attachment: 4.9.9p.a9.

Leave Election Form

Date: _____

To: DOAS/Risk Management Services
200 Piedmont Ave SE, Suite 1208 West
Atlanta, GA 30334
Fax 404-657-1188

From: _____ (Name of Injured employee)

Date of Injury: _____

Contact Number _____

Re: Workers' Compensation (WC) Benefit Payments

On the above referenced injury date, I was injured while working for _____ (agency name). If I lose any time from work because of this injury, I request that I be paid in the manner shown below. (Please initial beside the option you choose)

_____ From my accumulated sick leave and if necessary, from accumulated annual leave before receiving WC benefits for loss of wages. I understand that when I have used my accumulated sick and annual leave, I will receive WC benefits if I am still unable to work due to the injury.

_____ WC Benefits for loss of wages instead of full pay from accumulated sick and annual leave to be paid in regular weekly installments, effective _____ (date).

_____ From my accumulated sick leave and if necessary from my accumulated annual leave through _____ (date) after which time I wish to be paid WC benefits for loss of wages.

Signature of Injured Employee _____ Date _____

If a mark is used, two witnesses are required:

Witness

Date

Witness

Date