

## Process and Procedure Effective March 1, 2015

# **When Injured On The Job**

## **Filing a Claim**

All injuries and/or illnesses, on the job, whether requiring medical attention or not, must be reported to the supervisor immediately or within the current working shift after such occurrence. If the accident involves loss of consciousness, a fatality, broken bones, loss of a body part or third degree burns, the supervisor should be notified immediately. **It is then the responsibility of the supervisor to immediately notify the Safety Coordinator (office 615-898-7715).**

## **The following steps should be followed when injured:**

- Employees must report all injuries to their supervisor immediately or within the current working shift after such occurrence.
- Supervisors must call in notification of an OJI to the Risk Management Department within one (1) working day from the date of occurrence.
- Employee must select an authorized physician listed on the claim report. Once completed, the OJI claim report and the employee injury statement will be submitted to the Risk Management Department.
- The injured employee will file the reports with the Risk Management Department, whether medical treatment is necessary or not, within two (2) working days from the date of the event. The Safety Coordinator or designee (OJI Representative) will contact the supervisor and complete the supervisor's interview by phone or in person. (Once the form has been completed it will be sent to the supervisor for their signature).
- If an employee so desires, they may seek medical treatment from the physician they selected from the claim report. Do **not** go to your primary care physician or the in-house clinic— **it is not protocol and is not authorized. Non-authorized treatment will result in loss of benefits through the OJI Program.** (An employee has seven days to seek treatment from the day of the injury).
- ER visits are **NOT** protocol, unless there is a dire need (e.g. a broken bone, or bleeding profusely). Urgent Care facilities should be utilized on weekends during operating hours. However, if a work related injury happens after hours during the week or the weekend, you are permitted to utilize the ER – **provided your supervisor is aware of the injury.**
- Notify your supervisor of your condition and work status following medical treatment.
- To avoid out of pocket expenses for prescriptions, contact the Risk Management Department for a "First Fill Card" to present at authorized pharmacies. Employees **should not use** their health insurance plan or present their insurance card.
- If the physician recommends light or restricted duty and your supervisor can provide a job within your restrictions, you **MUST** report to work. Failure to report will terminate your OJI benefits.
- The supervisor shall complete the **Return to Work Agreement** by listing the light duty jobs that fall within the employee's restrictions. The supervisor shall also explain the restrictions to the employee and have the employee sign the agreement as acknowledgement of understanding the restrictions.
- If there is no light duty available, you will be out of work and paid through the OJI Program after the appropriate waiting period.

# On the Job Injury Checklist for Supervisors

When an injury occurs:

- If the injury is an **emergency**, call 911 or get injured worker to an emergency room.
- If injury is **not an emergency**, go over the Panel of Physicians with the injured employee and allow him/her to choose a physician. (Insure the employee **does not** go to their Primary Physician.)

**Note:** if injury occurs after hours during the week or the weekend, employees are permitted to utilize the ER

- Call the Safety Coordinator immediately or Risk Management Department, at 615-898-7715 or 615-405-5656 within (1) working day from the date of occurrence.
- Insure the following forms are completed on all injuries, accidents and/or illnesses whether medical treatment is necessary or not, within two (2) working days from the date of the event. The Safety Coordinator or designee (OJI Representative) will complete and sign off on all reports of injuries, accidents and/or illnesses.
  1. **Claim Report,**
  2. **Employee Injury Statement,**
  3. **OJI Supervisor's Report,**
  4. **OJI Witness Report,**

Forms are available at: [http://www.rutherfordcountyttn.gov/insurance/oji\\_forms.htm](http://www.rutherfordcountyttn.gov/insurance/oji_forms.htm)

- Review the **Post Injury Follow-Up sheet** with the injured employee to prevent out of pocket expenses and assure him/her that you are eager to see him/her return to work. Complete the **Return to Work Agreement Form** by listing light duty jobs that fall within the employee's restrictions. If there is no light duty available, the employee will be paid through the OJI Program. These forms are also available at the above website.
- Insure all of the above listed forms are completed and forwarded to the Safety Coordinator and or the Risk Management office, Fax: 615-867-4602

If you have any questions about reporting the injury, please contact the Safety Coordinator at 615-898-7715 / 615-405-5656 or email [dgoode@rutherfordcountyttn.gov](mailto:dgoode@rutherfordcountyttn.gov)

303 N. Church Street  
Murfreesboro, TN 37130

# RUTHERFORD COUNTY GOVERNMENT "ON-THE-JOB INJURY" CLAIM REPORT

Phone (615) 898-7715  
Fax (615) 867-4602

Claim  Report only

Claim # \_\_\_\_\_  
(Office Use Only)

Date of Injury: \_\_\_\_\_  
Date of Report: \_\_\_\_\_

Time of Injury: \_\_\_\_\_  
 AM  
 PM

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Risk Management Department.

Employee Name \_\_\_\_\_ Gender  F  M Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Date of Hire \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security No \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Location \_\_\_\_\_  
Injury Location \_\_\_\_\_  
Time employee began work on the date of injury: \_\_\_\_\_  
 AM  PM

Affected area (please "X" all appropriate areas). (If multiple areas are affected, please "X" all areas that apply).

- |                                  |                             |                              |                                   |                             |                              |                                |                             |                              |                                 |                                   |                             |                              |
|----------------------------------|-----------------------------|------------------------------|-----------------------------------|-----------------------------|------------------------------|--------------------------------|-----------------------------|------------------------------|---------------------------------|-----------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Ankle   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Elbow    | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Groin | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Mouth  | <input type="checkbox"/> Stomach  | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Arm     | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Eye      | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Hand  | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Neck   | <input type="checkbox"/> Shoulder | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Back    | <input type="checkbox"/> up | <input type="checkbox"/> lwr | <input type="checkbox"/> Face     | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Head  | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Nose   | <input type="checkbox"/> Thigh    | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Buttock | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Finger   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Hip   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Ribs   | <input type="checkbox"/> Toe      | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Cheek   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Foot     | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Jaw   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Teeth  | <input type="checkbox"/> Throat   | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Chest   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Forehead | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Knee  | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Throat | <input type="checkbox"/> Wrist    | <input type="checkbox"/> rt | <input type="checkbox"/> lft |
| <input type="checkbox"/> Ear     | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Genital  | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Leg   | <input type="checkbox"/> rt | <input type="checkbox"/> lft | <input type="checkbox"/> Skin   |                                   |                             |                              |

Injury Type (please X)

- |                               |                                   |                                  |                              |                                     |                                      |                                      |   |                                    |  |                                  |                                      |
|-------------------------------|-----------------------------------|----------------------------------|------------------------------|-------------------------------------|--------------------------------------|--------------------------------------|---|------------------------------------|--|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Burn | <input type="checkbox"/> Chemical | <input type="checkbox"/> Lifting | <input type="checkbox"/> Cut | <input type="checkbox"/> Human Bite | <input type="checkbox"/> Insect Bite | <input type="checkbox"/> Animal Bite | <input type="checkbox"/> Machine Injury | <input type="checkbox"/> Slip/Fall | <input type="checkbox"/> Student Assault | <input type="checkbox"/> Vehicle | <input type="checkbox"/> Other _____ |
|-------------------------------|-----------------------------------|----------------------------------|------------------------------|-------------------------------------|--------------------------------------|--------------------------------------|---|------------------------------------|--|----------------------------------|--------------------------------------|

Describe - please enter details of events causing injury. (Please be sure to enter what employee was doing just before the injury occurred.)

I hereby understand that all OJI Claims are investigated by the Rutherford County (RC) Risk Management Department. Completion of an OJI Claim Report and/or an Employee Injury Statement or attempting to file a claim does not guarantee acceptance of the individual claim. Therefore, after a full investigation of my claim, my claim may be non-compensable although I may have already seen an OJI Physician with OJI office approval. If that occurs, bills prior to the investigation will be paid in full by the Risk Management Department and I understand that I will be responsible for any further treatment or medication. I also understand that any unauthorized treatment or failure to seek medical treatment within 7 days of the injury will terminate my OJI benefits. I also hereby authorize the release of my protected health information from any and all health care providers, their employees, and agents and direct them to release or disclose to RC Risk Management Department (address above) my complete medical record regardless of stated areas of injury. I waive my right to confidentiality of these records for the purpose of an on-the-job injury. These records may be used by the RC Risk Management Department in making a determination as to my eligibility for benefits under the On-The-Job Injury Program. Unless otherwise stated, this authorization expires 365 days from the date of execution. Making a false or fraudulent claim is immediate grounds for termination from RC Government. I also understand the Safety Coordinator or their representative has the right to attend all visits with me and my physician. A physician must be selected from the list below.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Concentra<br>1203 A Memorial Blvd<br>Murfreesboro, TN 37129<br>Phone (615) 895-4855 | <input type="checkbox"/> Physicians Medical<br>1525 South Church St.<br>Murfreesboro, TN 37130<br>Phone (615) 217-7236 | <input type="checkbox"/> American Family Care<br>985 Industrial Blvd<br>Smyrna, TN 37167<br>Phone (615) 984-1000 | <input type="checkbox"/> Middle TN Occupational & Environmental<br>1227 Heil Quaker Blvd.<br>LaVergne, TN 37086<br>Phone (615) 641-3080 |
|--|--|--|---|

**INFORMATION:** Injury must be reported to the supervisor / Department Head immediately or within the current working shift. Care / treatment may be sought after the injury has been reported. When claim form is completed employee should fax report to the Risk Management Department @ (615) 867-4602.

Name of Supervisor Notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Has Employee scheduled a doctor's appointment.

Schedule Drs. Appointment:  Yes  No If so, Appt. Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 AM  PM

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OJI CLAIM REPORT



RUTHERFORD COUNTY GOVERNMENT  
"ON-THE-JOB INJURY" SUPERVISOR'S INTERVIEW

Information: This form will be completed by the OJI Representative in an interview with the supervisor of the injured employee.

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Risk Management Department.

Name of injured employee   
Supervisor's Name

Date of Injury:   
Phone number of supervisor

What Job / task was the employee performing when the injury occurred?

As a result of your investigation do you support this claim?  Yes  No If "not" what do you question about the claim?

In your own words, explain what the employee was doing and how the accident occurred:

In your opinion, could this accident have been prevented?  Yes  No Explain

What changes or recommendations would you support to prevent this injury from reoccurring?

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OJI SUPERVISOR'S INTERVIEW**

RUTHERFORD COUNTY GOVERNMENT  
"ON-THE-JOB INJURY" WITNESS STATEMENT

Information: This form must be completed by those individuals that witness an on-the-job injury to any Rutherford County employee.

As is allowed by T.C.A. 50-6-106, Rutherford County (RC) has opted to withdraw from the Tennessee Workers' Compensation Act, and instead has chosen to implement an On-The-Job Injury Program administered by the Rutherford County Risk Management Department.

Name of injured employee   
Name of witness

Date of Injury:   
Phone number of witness

What Job were you doing when the injury occur?

Did you actually witness the accident or injury?  Yes  No If "no" how do you know what happened?

What safety equipment was the injured employee wearing?

Was the injured employee required to wear safety equipment?  
 Yes  No If so what type?

Were any safety or work rules being violated at the time of the injury?  
 Yes  No If so what were they?

Was the injured employee performing their job as instructed?  
 Yes  No If not what changes were made and why?

What body part did the employee injury? (head, back, neck, etc)

Describe the injury. (strain, bruise, cut, etc)

What did the injured employee say at the time of the accident or injury?

Did the employee complain of pain? If so where?

In your own words, explain what the employee was doing and how the accident occurred:

In your opinion, could this accident have been prevented?  Yes  No Explain

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OJI WITNESS STATEMENT**



# Rutherford County Return to Work Agreement

(FOR USE WHEN AN EMPLOYEE IS RELEASED TO WORK WITH RESTRICTIONS.)

- The employee's restrictions **cannot** be accommodated.
- The employee's restrictions **can** be accommodated.

<b>If the restrictions can be accommodated, please list the jobs available to be done within the restrictions.</b>

<b>As doctor removes limits, adjust tasks and make note of them here. Please have employee initial changes.</b>

By signing this form, I am acknowledging that my restrictions have been explained to me. I understand that my restrictions apply to work and to my daily routines away from work.

\_\_\_\_\_  
Employee's Name (please print)

\_\_\_\_\_  
Employee's Signature

By signing this form, I am acknowledging that I have explained the restrictions to the employee.

\_\_\_\_\_  
Supervisor's Name (please print)

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date of this agreement

\_\_\_\_\_  
Date employee return to work without restrictions.

Please fax this form to the Safety Coordinator at 867-4602.  
Keep the original, along with a copy of the doctor's notes stating the employee's restrictions, in the employee's file.

## POST INJURY FOLLOW-UP

- Notify your supervisor of the status of your injury and when the physician recommends you return to work.
- To avoid out of pocket expenses for prescriptions, contact the Risk Management Department for a “First Fill Card” to present at authorized pharmacies. Employees **should not use** their health insurance plan or present their insurance card.

### The list of authorized pharmacies is as follows:

Reeves-Sain	LaVergne Drug	Wal-Mart (All Rutherford Locations)
CVS (All Rutherford Locations)	Krogers (All Rutherford Locations)	Publix (All Rutherford Locations)
Eckerd (All Rutherford Locations)	K-Mart (All Rutherford Locations)	Walgreens (All Rutherford Locations)

- If the physician recommends light or restricted duty and your supervisor can provide a job within your restrictions, you **MUST** report to work. Failure to report could terminate OJI benefits.
- If a job cannot be provided within your restrictions and you will miss work, have your supervisor fill out the **Return to Work Agreement Form** and fax it to the Safety Coordinator at 867-4602.
- Under the OJI Program, the date of injury and the first seven (7) days following the injury are the waiting period. Compensation begins on the eighth (8<sup>th</sup>) day of disability “**from work**”. **Consult your supervisor about the use of sick time for the seven-day waiting period.**
- Benefits are due for each day over the seven (7)<sup>1</sup> day waiting period until the lost time reaches fourteen (14) days. If you will be out of work beyond fourteen (14) days, you “**may**” qualify for temporary total disability benefits (TTD). Temporary total disability benefits will be calculated beginning with the day following the injury and will be paid biweekly.
- TTD benefits are based on 66  $\frac{2}{3}$  % of your gross average weekly wage for the last 52 weeks worked prior to the injury. This is called your weekly compensation rate and is subject to the minimum and maximum rates in effect on the day you were injured.
- If you refuse to comply with any reasonable request for medical examination or to accept medical treatment, your OJI benefits will be terminated.
- Depending on the extent of your injury, you will be contacted by CCMSI to verify details of your claim. This may include a recorded statement.

If you have any questions, please contact the Safety Coordinator at 898-7715.

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<sup>1</sup> Revised March 2015