THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

Workers' Compensation Employee Information

IF YOU ARE INJURED ON THE JOB:

1. Notify your supervisor/employer immediately. Contact your facility secretary (Food Service workers report to Food Service Manager) to complete a First Report of Injury/Illness form (Dept. of Labor Form DWC-1 (11/94)).
2. If you feel that medical treatment is necessary, notify your facility secretary, who will contact Risk Management. Risk Management personnel will then make the necessary authorizations. You must use a doctor/medical facility approved by Workers' Comp. Failure to use doctors/medical facilities approved by Workers' Compensation may require you to be responsible for payment (**health insurance does not cover work related accidents**).
    - **In the case of a more severe emergency, such as cuts, burns, etc., the Risk Management office will be contacted to determine if the claimant should go directly to the nearest hospital or to the medical facility contracted for your care. Notify your facility secretary as soon as possible so that treatment can be quickly authorized.**
3. **ALL** referrals are generated by the attending physician. Resultant appointments with specialists, therapists, etc., are scheduled for you by a third party administrator who will notify you with your appointment time and location. Any questions, contact Risk Management for clarification.
4. If you receive medical attention, you must relinquish all original paperwork pertinent to your physical 'work status' to your facility secretary, who will make copies for the facility and forward originals to the Risk Management Department at the County Office. *(You may wish to make copies for your files*).
5. If you have returned with any modifications other than normal duty, you MUST make sure that your facility secretary is made aware of the situation so that proper accommodations can be made. If the site is incapable of meeting those limitations, other arrangements will be made.

If you have questions regarding your Workers' Compensation claim, contact the **Risk and Benefits Management Department** at:

407-870-4057 Monday – Friday 8:00 a.m.- 4:30 p.m.

ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION COMMITS INSURANCE FRAUD, AND IS GUILTY OF A FELONY OF THE THIRD DEGREE. (*F.S. 440.105, 817.234*)

I attest that I have reviewed, understand, and acknowledge the information provided above.

PRINT Employee Last Name First Name Mid. Initial _____ - ____ - _____ Social Security Number

Employee Signature _____ Date Signed