To: All Employees

From: Risk Manager

Subject: Workers' Compensation Packet Instructions

When you have had an accident on the job, the forms listed below need to be filled out and returned to the Human Resources department **within 24 hours after the accident occurs**.

When an accident / injury occurs, call your supervisor immediately. If assistance is needed, please call the Risk Manager at (336) 242-2996 or the Safety Manager at 336-242-2212 during business hours.

After business hours, your primary contact will be the **Safety Manager, Cris Waugh at 336-309-2188**

Accident Investigation Report – Employee Description

Employee is to fill out this form **COMPLETELY**, every line. Each line is important.
Return to Risk Management/Safety within 24 hours of injury.

Email completed report to Amanda McEachin, Cris Waugh, and Nate Allman

amanda.mceachin@davidsoncountync.gov;crystal.waugh@davidsoncountync.gov;nathaniel.allman@davidsoncountync.gov

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Supervisor's Investigation Report

The supervisor should conduct a thorough investigation and then complete this report.

Again, please fill out **COMPLETELY**.

Accident investigation procedures:

Supervisors will investigate all accidents, injuries, and occupational diseases using the following investigation procedures:

- Implement temporary control measures to prevent any further injuries to employees.
- Review the equipment, operations, and processes to gain an understanding of the accident situation.
- Identify and interview each witness and any other person who might provide clues to the accident's causes, obtain a written statement from each witness.
- Investigate causal conditions and unsafe acts; make conclusions based on existing facts.
- Complete the accident investigation report.
- Provide recommendations for corrective actions.
- Indicate the need for additional or remedial safety training.

If you have any questions, call the Risk Manager at
336-242-2996

Or the Safety manager at 336-242-2212 After Hours Cell: 336-309-2188

Davidson County
Accident Investigation Report
Employee Description

Name _____SS# _____Date of Birth_____ Date of Hire_____

Home Address_____
Street City State Zip

_____
Employee's Home Phone Employee's Work Phone Employee's Cell Phone

_____
Supervisor's Name Supervisor's Work Phone Supervisor's Cell Phone

_____
Department Time work begins Position Hours worked per day Hours worked per week

Time Injury *Occurred*	Date Injury *Occurred*	Time Injury *Reported*	Date Injury *Reported*
AM		AM	
PM		PM	

Supervisor notified of Accident _____AM___PM___
Date Time

Injured Physical Description:
___Male ___Female ___Married ___Single ___Widowed ___Divorced Height_____ Weight_____ Hair_____ Eyes____

NATURE OF INJURY (Sprain, Strain, Laceration, Burn, Fracture, Bruise)
_____
_____
_____

PART OF BODY (Back, Finger, Hand, Foot, etc.)(Left, Right, Lower, Upper)
_____

DESCRIPTION OF ACCIDENT
_____
_____
_____
_____

SHARPS INJURIES (Provide Type of Device and Brand Name of Device)
_____
_____
_____

Exactly where did it happen: _____
Street Address City State Zip

I BELIEVE AN ON-THE-JOB ACT AND/OR CONDITION CONTRIBUTED TO THIS INJURY/DISEASE: ____☐____YES ____☐____NO

Employee Signature: _____DATE:_____

All injuries must be reported to the Risk Manager immediately or if medical attention is urgent, at the earliest possible time during business hours at 336-242-2211. The Risk Manager will assist in making sure the injured employee is sent to the appropriate, approved medical provider for treatment. **All written reports must be completed and sent to the Risk Manager within 24 hours after notification of the accident.**

Davidson County
Supervisor's Investigation Report

Employee's Name _____

Department _____Shift_____Position_____How long on this job_____

Address where employee reports to work: _____

Type of Incident	Minor Injury	Minor Illness	Major Injury	Major Illness
Check →	☐	☐	☐	☐

Nature and Extent of Injury (Body part, exact location, Sprain, Strain, Laceration, Burn, Fracture, Bruise)

_____

_____

Exact DATE/TIME injury occurred:	Date & Time reported:
Exactly WHERE did it happen:	
Exactly WHAT happened _____ _____ _____	
WHY did it happen? What were the individual causes?(Be specific-do not use the word "careless"): _____ _____ _____	

Were there any WITNESSES? Names, Telephone numbers _____
*Attach witness written statements if possible

TREATMENT: Treatment administered on the scene? ☐ YES ☐ NO
Medical treatment at this time? ☐ YES ☐ NO If yes, location of treatment _____

WAS THIS INJURY A RESULT OF AN UNSAFE ACT OF EMPLOYEE OR UNSAFE CONDITION? ☐ ACT ☐ CONDITION

What specific unsafe act(s) were responsible:_____

What specific unsafe condition(s) were responsible:_____

Why did this unsafe act or condition exist? ☐ Improperly trained ☐ Poor attitude ☐ Rushed, in a hurry ☐ Disobeyed safety rules ☐ Other, list

WHAT CORRECTIVE ACTIONS MUST TAKE PLACE TO PREVENT RECURRENCE?

_____

_____

_____

_____ _____

Investigator / Supervisor Date

Form 01/2024

Authorization

The undersigned has filed a claim for workers compensation benefits (hereafter referred to as the "Claim"). The amount and type of information sought pursuant to this authorization will depend upon the nature of the Claim, but will be used solely to facilitate determination regarding validity of the Claim and the payment of benefits or the administration of the insurance program under which the Claim has been made. Authorizing the disclosure of information is voluntary, and acceptance of the Claim will not be conditioned upon signing this authorization. This authorization is subject to revocation at any time, except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to Sedgwick, PO Box 183188 Columbus, OH 43218.

The undersigned authorizes the release of information and communication between his or her health care provider(s) (including, without limitation, medical laboratories, pharmacies, pharmacy benefit managers, and medical suppliers) and representatives of Sedgwick.

This release of information applies to all applicable medical records, medical information, bodily fluid and tissue samples, and benefit payment information with respect to any illness, injury, medical history, consultation, prescription, treatment, or benefit, and copies of all applicable records thereof, which may be appropriate or necessary throughout the course of this Claim. This authorization shall specifically include, but shall not be limited to, medical records, medical information and benefit payment information pertaining to or relating to the treatment of Acquired Immune Deficiency Syndrome, HIV, mental illness, and drug or alcohol related problems.

The undersigned also authorized the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors, to release to Sedgwick information concerning his or her workers compensation injury, entitlement dates and benefit amounts.

The undersigned further authorizes Sedgwick to release any such information to its reinsurers, attorneys, second injury fund consultants, or to medical laboratories, medical peer review panels, CMS, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or the undersigned's employer and its excess insurer, to the extent that Sedgwick considers doing so to be reasonably appropriate or necessary for the purposes of its administration of the Claim or the insurance program under which the Claim has been made.

Information disclosed to Sedgwick is from records whose confidentiality is protected by various state or federal laws. Any further disclosure of this information may no longer be subject to certain protections provided under federal privacy regulations. Unless revoked earlier by the undersigned, in writing, this authorization shall be valid for three years after Sedgwick has closed the Claim. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ **Date**_____

Employee Name _____ **Employer** _____
(Please Print) **(Please Print)**

Claim Number _____ **Date of Birth** _____

Please have injured employee report to the following:

Occupational Medicine Express Care

Thomasville Medical Center
Occupational Health
207 Old Lexington Rd.
Thomasville, NC 27360
336-474-8199

Present this information to Occupational Health to avoid bills being mailed directly to you, the employee.

Employer:
Davidson County Government
PO Box 1067
Lexington, NC 27293

County Contact: Amanda McEachin

Email: amanda.mceachin@davidsoncountync.gov
Phone: 336-242-2996

Cris Waugh
Email: cris.waugh@davidsoncountync.gov
Phone: 336-242-2212

Nate Allman
email: nathaniel.allman@davidsoncountync.gov
Phone: 336-242-2917

Workers Comp Insurance Billing Information:
Sedgwick
PO Box 14841
Lexington, KY 40512
(F) 866-548-2637

PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured person:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. In most cases, the pharmacy will fill the prescription at no cost to you.

If your workers' compensation claim is accepted, you will receive a permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Employer:

Immediately upon receiving notice of injury, fill in the information below and give this form to the employee.

Finding a network pharmacy

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® sedgwick®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Sedgwick — CARRIER/TPA

Davidson County — EMPLOYER

INJURED PERSON NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER — DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and to obtain the ID# for online adjudication of approved benefits for the injured individual.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

tmesys®

IMP14-2013-20