GUIDELINES FOR INJURED WORKERS
Special School District ("SSD")

All employees are covered by Workers' Compensation insurance and will receive benefits in accordance with current Missouri law. Employees must comply with the guidelines listed below.

Reporting an Injury

You must report all work-related injuries immediately (within 24 hours) to your SSD Supervisor, SSD Administrator (SSD Principal, Area Coordinator, Department Head, Manager), Nurse or Director's Secretary. It is **your** responsibility to complete the Employee Injury/Accident Report and submit it to the Insurance & Benefits Department immediately (within 24 hours) of the injury. Routing information is at the bottom of the Report.

Medical Treatment

Eligible medical expenses incurred because of a work-related injury/accident will be paid by Workers' Compensation benefits through Brentwood Services Administrators, Inc. ("Brentwood") as long as you obtain services from SSD-approved providers and follow SSD's Workers' Compensation guidelines.

Authorization for medical care must be obtained from SSD's Insurance & Benefits Department at (314) 989-8456 or Brentwood at (636) 812-9927. If you have a life-threatening injury/accident, call 911. If you require medical attention after regular business hours, please visit an urgent care or, if serious, the nearest emergency room.

If you choose to treat with your own physician, Workers' Compensation benefits will not cover the expenses and you will be responsible for payment.

It is your responsibility to keep scheduled doctor and/or physical therapy appointments and to follow the physician's order(s). Failure to do so may impact your Workers Compensation benefits. After each appointment, provide the physician's work status report to your SSD Administrator and SSD's Insurance & Benefits Department via email at workcomp@ssdmo.org or fax to (314) 989-8441.

Prescriptions

If you receive a prescription from an SSD-approved workers' compensation provider, you may have it filled at no cost to you. Notify the pharmacist that the prescription is for a work-related injury covered by Brentwood Services, through Carlisle Medical. The pharmacy will need the following: PCN# CAR, BIN# 019132, Group# F7761 and the Member ID is AW5P (plus your social security number). If you did not have this information and paid up front for prescriptions, you may be reimbursed through Brentwood.

Return to work

It is your responsibility to return to work when the physician says you are able to do so. If you are released to full duty or given restrictions, send your work status report to your SSD Administrator and SSD's Insurance & Benefits Department via email at workcomp@ssdmo.org or fax to (314) 989-8441. If the physician releases you to work with restrictions, Human Resources will provide guidance to your SSD Administrator on returning to work on a light-duty basis.

All SSD policies, including attendance, apply while working on a light-duty basis. If you miss work to seek approved medical care related to your injury, it is your responsibility to report your work hours accurately.

If you have any questions, contact SSD's Insurance & Benefits Dept. at (314) 989-8456.

EMPLOYEE ACCIDENT/INJURY REPORT
SPECIAL SCHOOL DISTRICT (SSD)

Entire Form Must Be Completed and Submitted by Employee* Immediately, Within 24 Hours of Injury

Employee's Name:_____ Employee ID: _____

Date of Birth:_____ Employee Contact Number:_____ Date of Hire: _____

Employee's Home Address: _____

_____

Job Title:_____ Date of Injury:_____ Time of Injury: _____

Building/District Employee Assigned: _____

Building/District/Location Where Injury Occurred: _____

Where did injury take place? (i.e., parking lot, hallway, cafeteria) _____

What part of the body was affected (if applicable, state left or right side)?

_____

Describe how injury occurred. **Be specific.**

_____

_____

_____

If the injury was student-related, please list the student's SSD ID number (no names):

Did the injury occur as a result of your regular job duties? ____ Yes ____ No

If No, please explain. _____

Did you seek care by a nurse in the building? ____ Yes ____ No

If Yes, Nurse's Name:_____ Phone No: _____

Did you seek medical treatment away from your facility? ____ Yes ____ No

If Yes, what medical care provider/facility? _____

If No, why? _____

Were there witnesses to the injury? ____ Yes ____ No

If Yes, list name(s) and telephone number(s): _____

Name of the person you notified and reported injury: _____

Position: ____ Nurse ____ SSD Supervisor ____ Director's Secretary

___ SSD Administrator (SSD Principal, Area Coordinator, Department Head, Manager)

When was injury initially reported to SSD? Date:_____ Time: _____

SSD Supervisor Name:_____ Phone Number: _____

Employee Signature:_____ **Date:** _____

I certify that the information provided above is accurate and complete. (Electronic signature accepted)

Submit this report immediately to SSD via email to workcomp@ssdmo.org or via fax at (314)989-8441.

For questions about completing this form, please call SSD's Insurance & Benefits Department at (314) 989-8456.

* In some situations, the Employee may need to provide information to an SSD Representative to complete the form on his/her behalf (hospitalized, etc.).