Jones Petroleum

Memo

Re: Workers Comp – Injured Employee (GA)

DURING INCIDENT ASSESSMENT:

1. **IMMEDIATELY** after an injury occurs, the employee is required to notify the immediate supervisor and store manager on duty**. **Treatment must be offered and ensure DAY OF INCIDENT****
2. Access the injury and determine if treatment is needed. IF the nature of the **injury is serious and requires immediate care**, the injured employee may seek treatment at the nearest walk-in clinic or urgent care. Employees should only go to the ER if the injury is life threating or after hours for clinic/urgent care. (Consult your panel of approved Doctors). Notify the HR department as soon as possible (770-775-2386)
3. **A mandatory drug and alcohol** screen is required for **ALL** worker comp injuries and should be completed at the treatment facility (**Drug test within 8hrs and Alcohol within 3hrs of incident**)
4. Fill out Workers Comp packet (for Manager & Injured). If the injury is **not life threatening** this should be completed **BEFORE** they seek treatment. The employee needs to take a copy of the First Report of Injury to the physician. Should the injury be life threatening have the employee portion filled out as soon as possible. The manager still needs to complete the First Report of Injury immediately.
5. Send completed packages to hr@jonespetroleum.com – Please note that this is a First Report of Injury with the employee's name.

FOLLOWING THE INCIDENT/TREATMENT:

1. Employees must provide documentation of doctors visit & determination – either Full Release WITH NO RESTRICTIONS or treatment plan for submission to the Worker Comp Carrier.
2. If not released within 6days, the manager must provide **13 weeks or employee timecards to submit to Carrier** (not including week of injury) **copy of the schedule** including the day of the injury.

- ***Any time someone is injured the packet must be completed.***
- ***Including when no medical treatment is required.***
- ***All injuries are to be treated by Panel Physician.***
- ***All injuries reported to management must be handled as outlined above.***

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Date of Injury	Employee Last Name	Employee First Name	M.I.	SSN:

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male ☐ Female	Birthdate	Phone Number	Employee E-mail
Mailing Address		City	State	Zip Code

EMPLOYER	Name: JONES PETROLEUM COMPANY	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
Mailing Address: 264 ALABAMA BLVD		Phone Number: 770-775-2386	Employer FEIN: 58-1343245
City: JACKSON	State: GA	Zip Code: 30233	Employer E-mail

INSURER / SELF-INSURER	Name: Federated Mutual Insurance Co	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
CLAIMS OFFICE	Name: Federated Mutual Insurance Co	Claims Office FEIN #	Claims Office Phone: 888-333-4949 / Claims Office E-mail: pcclaims@fedins.com
SBWC ID# (five digit no.)	Mailing Address: PO Box 486	City: Owatonna	State: MN / Zip Code: 55060

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code: ☐I – Insurer ☐S-Self-insurer ☐Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: Returned at what wage per Week If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability: _____

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	**E-mail**	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation.

3. If you need additional help, call your insurance company or self-insurer claims office.

4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct Insurance Company and their SBWC ID number.

Complete Section B, Co or D and file with the Board and send a copy of both sides of the form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

Employee's Report of Injury Form

Instructions: Employees shall use this form to report all work-related injuries, illnesses, – *no matter how minor*. This form shall be completed by employees as soon as possible and given to a supervisor for further action.

Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury? ❑ Yes ❑ No When did you tell your supervisor? Date: Time:	
Date of injury:	Time of injury:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury. (Continue on the back if necessary):	
What could have been done to prevent this injury?	
What parts of your body were injured?	
Will you seek medical attention at the time of injury/illness? If yes, when were you seen: ❑ Yes ❑ No	
If yes, who did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? ❑ Yes ❑ No	
If yes, when?	Supervisor:
Your signature:	Date:

Supervisor's Accident Investigation Form

Name of Injured Person _____

Paylocity Badge ID # _____ Store Number _____

Date of Hire _____

(Check one) ☐ Male ☐ Female

Photos Taken? ☐ Yes ☐ No Photos Attached? ☐ Yes ☐ No

What part of the body was injured? Describe in detail. _____

_____

What was the nature of the injury? Describe in detail. _____

_____

_____

Describe fully how the accident happened. What was the employee doing prior to the event? What equipment and/or tools being using? _____

_____

_____

Names of all witnesses:

_____ _____

_____ _____

Date of Event _____ Time of Event _____

Exact location of event: _____

What caused the event? _____

_____

_____

Were safety regulations in place and used? If not, what was wrong? _____

_____

Employee went to doctor/hospital? Doctor's Name _____

Hospital Name _____

Recommended preventive action to take in the future to prevent reoccurrence.

_____

_____

_____

_____ _____

Supervisor Signature Date

****HR -prior to sending FROI make sure you run Employee Summary Report and attach****

Incident Report

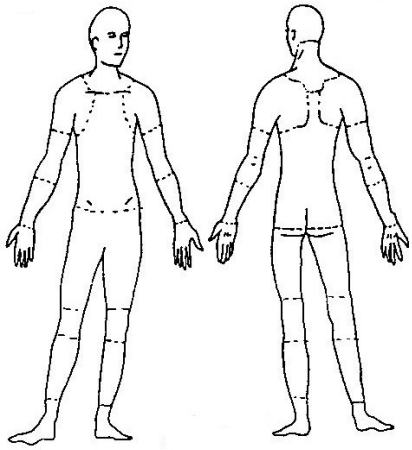
Instructions: Supervisor completes this form as soon as possible after an incident that results in any injury.

This is a report of a: ❑ Death ❑ Lost Time ❑ Dr. Visit Only ❑ First Aid Only	
Date of incident:	This report is made by: ❑ Employee ❑ Supervisor

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: ❑ Male ❑ Female	Age:
Location:	Job title at time of incident:	

Part of body affected: (shade all that apply)



Nature of injury: (most serious one)
- ❑ Abrasion, scrapes
- ❑ Amputation
- ❑ Broken bone
- ❑ Bruise
- ❑ Burn (heat)
- ❑ Burn (chemical)
- ❑ Concussion (to the head)
- ❑ Crushing Injury
- ❑ Cut, laceration, puncture
- ❑ Hernia
- ❑ Illness
- ❑ Sprain, strain
- ❑ Damage to a body system:
- ❑ Other _____

This employee works:
- ❑ Regular full time
- ❑ Regular part time
- ❑ Seasonal
- ❑ Temporary

Months with this employer

Months doing this job:

Step 2: Describe the incident

Exact location of the incident:	Exact time:

What part of employee's workday? ❑ Entering or leaving work ❑ Doing normal work activities. ❑ During meal period ❑ During break ❑ Working overtime ❑ Other_____

Names of witnesses (if any):

What personal protective equipment was being used (if any)?

Describe step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials, and other important details.

Description continued attached sheets: ❑

Step 3: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)	Unsafe acts by people: (Check all that apply)
❑ Inadequate guard ❑ Unguarded hazard ❑ Safety device is defective. ❑ Tool or equipment defective ❑ Workstation layout is hazardous. ❑ Unsafe lighting ❑ Unsafe ventilation ❑ Lack of needed personal protective equipment. ❑ Lack of appropriate equipment / tools ❑ Unsafe clothing ❑ No training or insufficient training ❑ Other: _____	❑ Operating without permission ❑ Operating at unsafe speed ❑ Servicing equipment that has power to it ❑ Making a safety device inoperative ❑ Using defective equipment ❑ Using equipment in an unapproved way ❑ Unsafe lifting ❑ Taking an unsafe position or posture ❑ Distraction, teasing, horseplay ❑ Failure to wear personal protective equipment. ❑ Failure to use the available equipment / tools. ❑ Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Have there been similar incidents prior to this one?	❑ Yes ❑ No

Step 4: Who completed and reviewed this form? (Please Print)

Written by: Department:	Title: Date:
Notes:	
Reviewed by:	Title: Date: