

Workers Compensation Instructions for Managers and Supervisors

1) Determine the extent of injury (or illness). If it is an emergency, call 911 and notify HR immediately. If non-emergency medical treatment is necessary or requested by the employee, notify HR so that a medical treatment authorization can be provided and send the injured/ill worker to the company's designated clinic. Employees who receive medical treatment will be required to take a post-accident substance abuse test.

BayCare Urgent Care (see attached sheet for location/hours)

Adhere to all instructions given by the worker's comp. physician, if applicable, and ensure that the employee does.

If an employee is injured or becomes ill during work at a time when the clinic is unavailable, depending upon the urgency of the situation, either direct the employee to the ER or have them visit the clinic at the next opportunity.

2) The employee must complete the HR Report of Injury/Illness form available on Employee Connect. Information provided on the form regarding the injury/illness and how it occurred must be very detailed. This may require further questioning of the employee and/or any witnesses.

VERY IMPORTANT: Injuries/illnesses that occur during the scope of someone's employment must be reported as soon as possible by regulation. Submit the completed HR Report of Injury/Illness form to Human Resources the same day that you become aware of the injury/illness.

Please note:

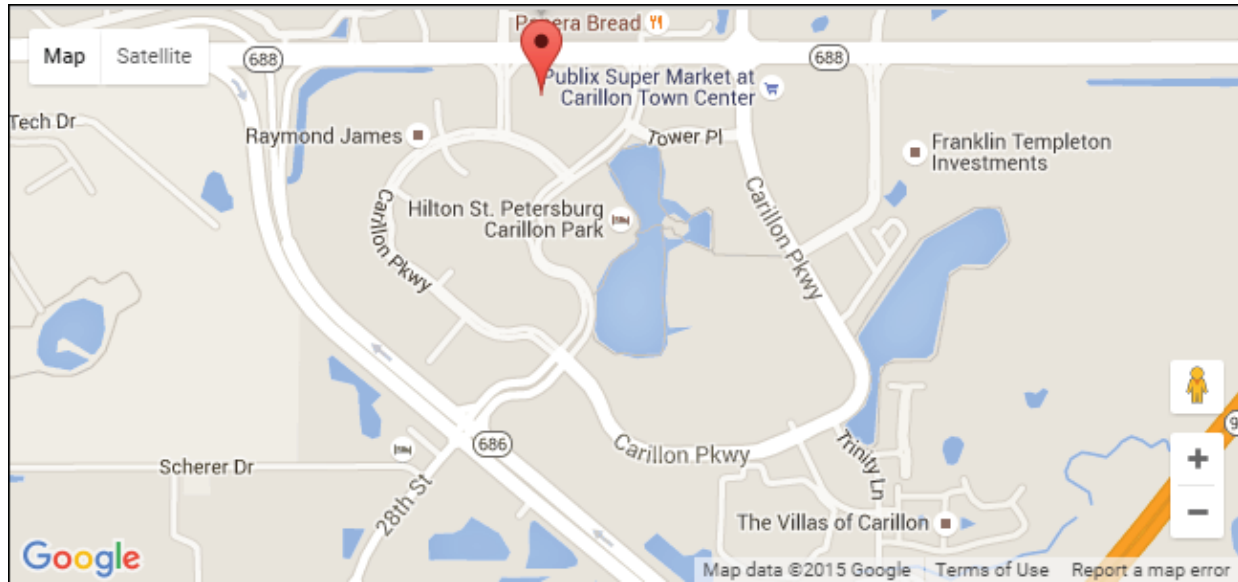
- Please use your best judgment to determine whether the injury/illness requires medical treatment. Ask yourself, "If this happened to someone in my home and they sustained the same injury/illness, would I a) call 911 and/or b) take them to the doctor?"
- If the employee requests to see a physician, direct them to seek medical attention at our designated location. Please fill out and sign the attached form and have the employee bring it with them to our designated location.
- If the employee does not wish to seek medical treatment, they do not have to go. If it obvious that they need care (broken bone, severe cut) and they don't want to go, they should be strongly encouraged to go. If they refuse, we should document the refusal.
- If the work comp. physician requires time away from work related to the injury, it can be company paid time up to 40 hours (coded as "workcomp" in Kronos). Additional time missed that is not required by the designated physician will be at the employee's own expense (PST, PTO or unpaid and occurrences will apply per the attendance policy).

3) In the event a member of HR is not available to be notified please contact our Workers Compensation insurance carrier Zurich directly at 1-800-987-3373 if you have additional questions or need to find a different clinic

Florida Locations

Main Location: BayCare

900 Carillon Parkway Ste. 106
St. Petersburg, FL 33716
Phone: 727-561-2670
Office Hours Monday-Friday 8:00am-6:00pm

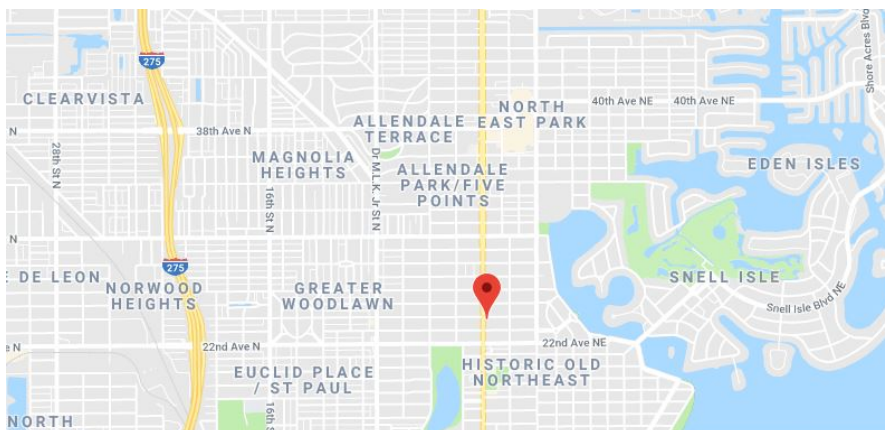


St Petersburg Locations: Weekends and weekday early evenings

BayCare Urgent Care Clinics

Option 1

BayCare - NE St. Pete
2331 4th Street North
St. Petersburg, FL 33704
Phone: 727-914-8566
Office Hours are:
Monday - Friday 8:00am - 8:00pm
Saturday and Sunday: 9:00am - 6:00pm



Option 2

BayCare - Clearwater

711 S Belcher Road

Clearwater, FL 33764

Phone: 727-314-4848

Office Hours are Monday - Friday 8:00am - 8:00pm

Saturday and Sunday: 9:00am - 6:00pm



In the event a member of HR is not available to be notified please contact our Workers Compensation vendor directly at 1-800-987-3373 if you have additional Questions or need to find a different clinic.

The Employer Authorization form for BayCare clinics is below.

Employer Authorization Form

Please complete and present at the time of service along with photo ID

Patient Name: _____ Date: ____/____/____

FIN#: _____

Company: PSCU Phone: (727) 571-7989 Fax: () -

Company Address: 560 Carillon Pkwy, St. Petersburg, FL, 33716

Primary Contact (DER): Kim Wetherington and Stephanie Byrn

Requested Services *(check all that apply)*

Work Related Injury Treatment

Workers' Compensation Injury Treatment:

Date of Injury: _____

Type of Injury: _____

Post-accident Drug Screen Required (select below)

Drug and Alcohol Screening

Rapid Drug Screen: 5-panel

Test Reason (pick reason below):

Pre-employment Random

Reasonable Suspicion

Post-accident

Return to Duty

Follow-up

Additional Workers' Compensation Information

Has Employer filed Notice of Injury? Yes No *(please provide copy if available)* Claim #: _____

W/C Carrier: See account profile for details Policy #: _____

Address: _____ Phone: (____) _____ -

Authorization

*** *Must bring authorization form to clinic* ***

- I certify that the above information is correct.
- I authorize the medical provider to provide medical treatment to the employee named above.
- I understand all services not covered by insurance will be the employer's responsibility.

In-office Staff use only:

- Verbal authorization obtained from Employer Representative
- Performed per instructions listed in Accounts Database.

Initials: _____ Date: _____

Authorized Representative Signature: _____

Authorized Representative (print name): _____

Position/Title: _____ Date: ____/____/____

