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WESTPORT PUBLIC SCHOOLS
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NANCY J. HARRIS
Assistant Superintendent for Business

TO: All Employees

FROM: Nancy J. Harris

DATE: *August 19, 2010*

SUBJECT: Initial Provider - Workers' Compensation Program Procedure

The Westport Board of Education participates in the Connecticut Interlocal Risk Management Agency (CIRMA) Preferred Provider Network and Managed Care Plan. CIRMA has organized a network of physicians and other medical service personnel to provide high quality care for employees in the event of a Workers' Compensation injury.

At the first report of an employee's injury, the Supervisor/Administrator must fill out the attached Workers Compensation Employee Injury Form and then call CIRMA at 1-800-652-4762 within 24 hours to report the work injury.

PLEASE NOTE:

Employees with a work-related injury or illness must be referred to the following health care centers for initial treatment:

As a courtesy, please call first: 203-852-2417 – An appointment is not required
Occupational Health Services of Norwalk Hospital
520 West Avenue
Norwalk, CT 06850

A prescription drug card which allows injured workers to obtain needed medication from a participating pharmacy with no out-of-pocket expense is available at the office of the Assistant Superintendent for Business.

IMPORTANT NOTE: As of July 1, 2001, any employee that obtains medical services from a provider outside the CIRMA Provider Network, shall suspend their right to receive compensation, subject to the Workers' Compensation Commissioner's order.

Attached is a Workers Compensation Employee Injury Form. Once you have completed and reported an injury, please forward a copy of the Injury Form to the office of the Assistant Superintendent for Business.

Westport Public Schools
Workers Compensation
Employee Injury Form

This Form must be completed by any employee other than the injured employee.

CIRMA must be notified NO LATER than 24 hours after injury at 1-800-652-4762

ALL SECTIONS MUST BE FILLED OUT COMPLETELY

NAME _____ **DOB** _____ **Date of Hire:** _____

ADDRESS _____ **HOME TEL:** _____

SOCIAL SECURITY NO: _____ **SCHOOL** _____

OCCUPATION _____ **TIME EMPLOYEES WORKDAY BEGAN:** _____

DATE OF INJURY _____ **TIME OF INJURY** _____

PLACE OF INJURY _____

HAS EMPLOYEE LEFT WORK **YES:** ☐ **NO** ☐ **HAS EMPLOYEE RETURNED TO WORK** **YES:** ☐ **NO** ☐

TIME EMPLOYEE LEFT WORK _____ **AM PM** **DATE RETURNED** \ \

DESCRIBE THE EVENTS WHICH RESULTED IN THE INJURY OR DISEASE

INDICATE PART OR PARTS OF BODY AFFECTED (please provide as much information as possible)

WHAT WAS EMPLOYEE DOING IMMEDIATELY PRIOR TO THE INJURY?

WHAT WAS OBJECT OR SUBSTANCE INVOLVED IN THE INJURY?

LIST ANY WITNESSES:

HAS EMPLOYEE TREATED PRIOR TO FIRST REPORT OF INJURY? IF SO, LIST PHYSICIAN'S NAME

SUPERVISOR'S NAME AND TITLE (print or type)	**DATE**	**SUPERVISORS SIGNATURE**

cc: Business Office - TSO **CIRMA 1-800-652-4762**