Information Guide for a Workers' Compensation Claim

Date of Injury:_____

_____ Report injury to facility.

_____ Complete the Accident/Injury Report and the Benefit Election form at your facility. Call ARS (888-800-0029) to report injury to State Insurance Fund.

_____ Obtain prompt medical treatment in an Emergency Room, Urgent Care or with personal physician and advise providers the NYS Insurance Fund is the Workers' Compensation carrier. Any treating provider must have certification from the Workers' Compensation Board (WCB) to treat Workers' Compensation injuries. It is important to ask the physician, prior to making an appointment, if he/she is able to treat Workers' Compensation claims. Most Emergency Rooms and Urgent Care facilities have approval from the WCB.

_____ Complete a C3 (new injury) or C3.3 (prior injury to same part of body) and mail to:

Workers' Compensation Board
Centralized Mailing Address
PO Box 5205
Binghamton, NY 13902-5205

The C3 can also be completed electronically on the Workers' Compensation Board website at **www.wcb.ny.gov**

_____ Provide disability notes to facility even if it only involves one day after the injury. All the information requested on the Documentation **for Workers' Compensation Leave** form must be completed.
Failure to do so may result in a pay status change. It is not necessary to use the leave form; however all the information requested on the leave form must be provided on a physician's letterhead.
It is your responsibility to make sure all the information is completed correctly.

_____ Review the Workers Compensation Statement of Rights and Legislation regarding injuries from an assault.

_____ Review the Pharmacy Network Information.

_____ Review Diagnostic Testing Network

_____ Obtain and keep copies of all notes provided to facility that pertain to treatment, such as:

- _____ Facility injury report
- _____ Names of witnesses
- _____ Emergency Room report – make sure to obtain an out-of-work note, if applicable
- _____ **All** phone calls/dates
- _____ **All** correspondence from the State Insurance Fund and the Workers' Compensation Board
- _____ **All** correspondence from your facility
- _____ Mileage including dates of treatment related to your injury - MD/chiropractic visits, physical therapy, Independent Medical Examination (IME). These are expenses that should be sent to the State Insurance Fund for a reimbursement of out-of-pocket expenses.

_____ If your WC claim is controverted (not accepted) or you are placed on LWOP, YOU HAVE **20** DAYS TO FILE A GRIEVANCE after you receive notification. Refer to FAQ for further information.

_____ IME information – see FAQ for more information.

_____ Review the Dispute Resolution appeal form and information.

_____ Review the New York State Department of Correctional Services Directives:
- # 2207 Time & Attendance Rules – Personal leave
- # 2208A Workers Compensation Benefits – (Security Services)

_____ Review the New York State Department of Civil Service Attendance and Leave Manual – Policy Bulletin 93-02 Section 21.8

_____ Review the NYSCOPBA Contract, Article 14.9 (included).

All forms are provided in "Table of Contents"

Reviewed: 5/30/19

OTHER WORKERS' COMPENSATION
FREQUENTLY ASKED QUESTIONS

1. My claim has been controverted by Workers' Compensation.

The State Insurance Fund (SIF) may controvert a claim when information is missing or when there is something unusual. For example, they receive a claim from a person and there is no report from their employer or their physician that an injury occurred.

- File a grievance within twenty days of receiving any notification that your claim is controverted. This includes verbal notification from your facility or formal notice from SIF.
- Obtain an attorney and have him/her request a hearing with the WCB.
- Make sure your physician has submitted all medical documentation to both the State Insurance Fund and the Workers Compensation Board.
- Continue appropriate medical treatment. Your physician will then submit progress reports to the State Insurance Fund.
- Continue to provide documentation for Workers' Compensation leave if you are out of work.

2. The WC decision was not in my favor.

- Both sides in a WC hearing have 30 days to appeal a WC decision.
- Talk with your attorney about appealing the decision.

3. What happens when my grievance goes to arbitration?

- When a grievance goes to arbitration, more information may be needed.
- The request for additional information will be sent to you from the NYSCOPBA attorney handling the grievance.
- Provide the requested information within the time specified.

4. Independent Medical Examinations (IME) scheduled by the State Insurance Fund (SIF)

- As a condition of receiving WC Contract benefits, you can be required to attend an IME.* If you miss the IME or reschedule it your benefits under the Medical evaluation program may be stopped and you will come off the 14.9 contract benefit.

- You may bring someone into the exam room with you. You may also audio or videotape the exam. Make sure to read the instructions on your appointment notice for details regarding this action. A recent Workers'
- Compensation Board decision clarifies this as follows: "An IME examiner may not refuse to conduct an IME when a claimant appears at the IME prepared to record or videotape an IME."
- Copies of your IME will be sent to you, your attorney (if you have one) and your physician within 10 business days.
- **Once received, you should make an appointment to discuss the results with your physician to determine whether he is in agreement with the information.**

5. I was ordered back to work after an Independent Medical Examination (IME) scheduled by the State Insurance Fund and my Doctor says I should not return to work.

- In the report, the physician may state you can work either light duty or full duty. The IME physician completes an Estimated Physical Capabilities Form and your facility may then order you to return to work depending on the IME report. You should make an appointment to SEE YOUR TREATING PHYSICIAN once you have received IME results to discuss whether he agrees with the return to work information stated in the IME.
  If he does not agree you can begin the Dispute Resolution Process (DRP) through National Medical Review (NMR) and provide an explanation letter to your physician.
  If NMR agrees with your physician, you may remain out of work.
  If NMR agrees with the IME physician, you must return to work or you will be placed on LWOP.
- Information regarding the DRP is included in this packet.

6. What is the statutory benefit?

- The statutory benefit is the amount of money (wages) you can receive directly from SIF based on WC law. The maximum amount you can receive is established at the date of your injury, based on the rate at that time. The exact amount you receive depends on the level of your disability, as determined by your physician or the IME physician.

7. Is the statutory benefit taxed?

- The statutory benefit is non-taxable.
- While you are in pay status through the contract benefit, taxes are withheld.
- You are entitled to a refund for your taxes.
- Information regarding taxes is included in this packet.

8. I am back at work. Do I have to charge WCL or my accruals to attend the IME exam?

- There should be no charge to WCL or accruals to attend this exam.

9. I am back to work and the IME is scheduled on my day off. What should I do?

- Attend the exam. You are entitled to be paid overtime (if eligible) for the time spent attending the exam, as well as for time spent commuting to and from the exam.
- If you are denied such payment, contact your Regional VP, Business Agent or the grievance department.

10. My doctor has released me to return to work light duty. What do I do?

- Your provider can request light duty for up to 60 days. The note must state the date you can return to full duty. The return to work full duty date should be no more than 60 days from the date of the beginning of light duty. If your doctor is reluctant to provide a clear full duty date, advise him/her that you will not be allowed to return to work without a date.
- This date is an estimate. You can always be re-evaluated by your physician while working light duty.
- Bring the note requesting light duty to your facility. Your physician should use the ERS 101, Estimated Physical Capabilities Form, so that your abilities and limitations are clearly stated. It is not necessary to send the physician's complete narrative report.
- If you are not allowed to return to work light duty, call NYSCOPBA's main office to speak to Dana Betts, Ext. 247.

11. My doctor has released me to return to work full duty.

- Bring the note releasing you to return to work to your facility. The Information must specify that you can return to full duty without any restrictions. The facility does have the right to have you examined by an Employees Health Services (EHS) physician prior to approving a return to work full duty.

12. My doctor says I might not be able to return to work.

- Call William Naylor at NYSCOPBA Ext. 257, to obtain information about Disability Retirement call Sharon Smith at Ext. 236, regarding any questions you have about Health Insurance.
- Talk with your workers' compensation attorney about the long term benefits for which you may be eligible.

13. Do I earn accruals while I am out on WCL?

- You earn accruals anytime you are in pay status.
- You do not earn accruals while out on 1/2 pay.

14. Do I receive holiday compensation pay or compensatory time off while I am disabled due to a work-related injury?

- During the first 6 months while you are on full pay you **will not** earn holiday pay or compensatory time off.
- Once you start using your accruals after 6 months, you **will** earn holiday pay and compensatory time off.
- You are entitled to receive personal leave time once you return to work.

15. Can I get my accruals back?

- Once you are back to work full duty, your facility will report the amount of time off used for your Workers' Compensation Injury to the WCB and SIF.
- SIF will then complete a FROI form reporting the time off for your Workers' Compensation injury. This form is sent to the WCB, you, your attorney, your facility and the Comptroller's Office.
- **It is very important to keep this form.**
- Restoration of accruals is based upon the FROI form.
- Restored accruals cannot be used again for the same injury.

16. Do I have to wait until a Workers' Compensation hearing to be reimbursed for out of pocket expenses and mileage?

- If your claim is established and accepted by the State Insurance Fund you can submit your expenses for reimbursement at any time.

17. I have been out of work for almost a year. Will I be terminated?

- If the disability was NOT due to an assault sustained in the course of employment, you are entitled to one full year of **cumulative** absence for a work-related injury. If you are able to return to duty before the year is up, you cannot be terminated.
- If the disability is the result of an assault sustained in the course of employment, you are entitled to two years of **cumulative** absence for a work related injury. If you are able to return to duty before the time expires, you cannot be separated from service.
- If you or your doctor believes that you will be unable to return to duty within the one year time frame, you should contact your regional NYSCOPBA Vice President or Business Agent and request to be referred to a NYSCOPBA attorney.
- If you are permanently disabled from the duties of your position, you may be eligible for a disability retirement. The disability retirement application process can take some time, so application should be made as early as possible.
- If you are released to return to work, you may be scheduled for an Employee Health Services examination with a state physician.
- If this occurs, you should bring with you:
  - a medical release from your physician
  - medical reports from your physician clearly stating your injury, that you are recovered and are capable of performing all your job requirements.

18. I am on LWOP or I have been terminated from service due to extended absence. Can I get any money?

- You may be eligible for the statutory benefit paid to you by the State Insurance Fund if your claim was accepted by the WCB and you remain disabled. Your facility should notify SIF about your pay status. Contact SIF claim handler or your attorney should you have one. A hearing may need to be scheduled with the WCB to address this issue.

19. I received a bill for my health insurance. What should I do?

- Contact Civil Service Health Benefits at 1-800-833-4344 from 9AM to 3PM, Monday through Friday or NYSCPBA's Health Benefits Specialist Sharon Smith at ext. 236

20. My facility is also charging my Workers' Compensation Leave time to the FMLA? Can they do that?

- FMLA regulations allow employers to charge WCL concurrently with Family Medical Leave.

Additional information can be found below:

- NYSCOPBA: www.NYSCOPBA.org (links to SIF, WC, and MANY other resources)
- Workers' Compensation Board: www.wcb.ny.gov
- State Insurance Fund: www.nysif.com.
- Retiree Information for restoration of accruals

This information is not legal advice. Contact your Workers' Compensation attorney for specific legal information regarding your legal rights in a workers' compensation or disability matter.

Reviewed 12/4/2018

HELPFUL PHONE NUMBERS FOR WORKERS' COMPENSATION CASES

NYSCOPBA 1-888-484-7279
or
518-427-1551

TOPIC	ASSISTANCE PROVIDED	PHONE NUMBER OR EXTENSION AT NYSCOPBA	CONTACT
Accident Reporting System (ARS)	To report injury.	1-888-800-0029	Automated System
Workers' Compensation	Answer questions pertaining to WC and the NYSCOPBA contract.	247	Dana Betts, RN
Disability Pension	Explanation of disability pension process. Provides information and forms.	257	William Naylor
Medical Benefits	Explanation of health insurance when payroll status changes.	236	Sharon Smith
Norvest	If enrolled for optional disability insurance.	1-888-869-8252	Norvest Customer Assistance
Aflac	If enrolled for Accident/Sickness	1-800-366-3436	AFLAC Customer Assistance
Membership Services	Resolve problems with Norvest/Aflac Provide information to members leaving state payroll.	261	Stephanie Flanagan
Specialists/Physicians	List of specialists who accept WC cases.	1-877-632-4996	Website – www.wcb.ny.gov
Advocate for the Injured Worker	Answers questions pertaining to your specific case.	1-877-632-4996	Website – www.wcb.ny.gov

Table of Contents

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:

For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee	Date	Signature of Witness	Date

Please note: It is not necessary for you to sign this consent form if your employer is (i)participating in a certified preferred provider organization (PPO) under Article 10-A of theWorkers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR)pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance withthese statutory programs, except in emergency situations, you must obtain at least initialtreatment for any workers' compensation injury or illness from the certified network(s) orproviders designated by your employer.

To the Employer:

The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

STATEMENT OF RIGHTS

TO ALL WORKERS WHO ARE INJURED WHILE WORKING OR WHO SUFFER FROM AN OCCUPATIONAL DISEASE

YOU MAY BE ENTITLED TO WORKERS' COMPENSATION BENEFITS

1. You should file a claim for benefits within two years of the date you are injured, unless your injury is very minor, requiring no medical treatment and causing no lost time from work. If you do not file within two years your right to benefits may be lost. Obtain and file a claim form (Form C-3, or VF-3 for volunteer firefighters, or VAW-3 for volunteer ambulance workers) with the nearest Workers' Compensation Board office (see addresses below).
2. You may be entitled to lost time benefits if your work-related injury keeps you from work for more than seven days, compels you to work at lower wages or results in permanent disability to any part of your body. You may be entitled to rehabilitation services if you need help returning to work. (In volunteer firefighters' and volunteer ambulance workers' cases, compensation for lost time or loss of earning capacity may be payable from date of injury.)
3. You are entitled to obtain any necessary medical treatment related to your injury and you should do so immediately.
4. For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Board authorized and who is accepting workers' compensation patients. If, however, your employer is involved in a certified preferred provider organization (PPO) arrangement, you must obtain initial treatment for any workers' compensation injury or illness from the preferred provider organization. Employers participating in this statutory program are required to provide their employees with written notification describing their employees' rights and obligations under the program.
5. You should inform your doctor to file copies of medical reports concerning your claim with the Workers' Compensation Board and your employer's insurance company, which is indicated at the bottom of this form.
6. You should not pay any medical providers directly for treatment of your work-related injury or illness. They should send their bills to your employer's insurance carrier. If there is a dispute, the provider must wait until the Board makes a decision before it attempts to collect payment from you. If you do not pursue your claim or the Board rules that your injury is not work-related, you may be responsible for the payment of the bills.
7. The employer is liable for the replacement or repair of an employee's prosthesis (e.g., artificial members, false teeth, eyeglasses), which has been lost or damaged in the course of employment, whether or not there was bodily injury to the employee. You are also entitled to be reimbursed for drugs, crutches or any apparatus properly prescribed by your doctor, and transportation and other necessary expenses going to and from your doctor's office or hospital. (You should get receipts for all such expenses.)
8. You are entitled to be represented by an attorney or licensed representative, but it is not required. If you do hire an attorney or licensed representative, you should not pay him/her directly. Any fee will be set by the Board and will be deducted from your award.
9. Lost time and medical benefits are payable directly without a formal direction from the Board, unless your claim is disputed. If your claim is disputed on the grounds that your injury is not work-related or did not arise in the line of volunteer firefighter or ambulance worker duties, then you may qualify for disability benefits for non-work injuries. For more information on entitlement to disability benefits, contact the Workers' Compensation Board office nearest you.
10. You should go back to work as soon as you are able; compensation is never as high as your wage. If you need help returning to work, or with family or financial problems because of your injury, you should contact the nearest Board office and ask for a rehabilitation counselor or social worker.
11. Your employer may not ask you to waive your right to compensation nor may your employer deduct any money from your pay to contribute to the payment of workers' compensation insurance premiums. Further, you cannot be discharged or discriminated against because you filed a claim for workers' compensation benefits.

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A JOB-RELATED INJURY OR DISEASE, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights under the Workers' Compensation Law. It is provided, as required by Section 110 of the Workers' Compensation Law, by your employer's insurance carrier:

CHAIR
WORKERS' COMPENSATION BOARD

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

Stato di New York
WORKERS' COMPENSATION BOARD

Informativa sul diritto di scelta di un professionista/struttura sanitaria autorizzato dalla Workers' Compensation Board

Nome del dipendente vittima di infortunio	N. di previdenza sociale del dipendente vittima di infortunio	Data dell'incidente
Nome e indirizzo del datore di lavoro		

Al dipendente vittima di infortunio:

Per il trattamento del proprio infortunio o malattia correlata alla professione, sarà possibile rivolgersi (su segnalazione del medico autorizzato) ai medici, podologi, chiropratici o psicologi autorizzati dalla Workers' Compensation Board che accettano di curare i pazienti coperti da assicurazione sul lavoro.

Anche nell'eventualità in cui si decida di rivolgersi a una rete di assistenza sanitaria o a un professionista/struttura sanitaria indicato dal proprio datore di lavoro o dalla rispettiva compagnia assicurativa per infortuni sul lavoro, o se, invece, si consente al proprio datore di lavoro di scegliere un professionista/struttura sanitaria per proprio conto, sarà comunque possibile rivolgersi a diverso professionista/struttura sanitaria in qualsiasi momento senza compromettere in alcun modo la richiesta di indennizzo per infortunio sul lavoro.

Firma del dipendente vittima di infortunio	Data	Firma del testimone	Data

Attenzione: Non è necessario firmare il modulo di consenso se il proprio datore di lavoro: (1) è membro di organizzazione di prestatori di assistenza sanitaria convenzionati (PPO) ai sensi dell'Articolo 10-A della Workers' Compensation Law; (2) partecipi a programma pilota di soluzione alternativa delle dispute (ADR) secondo quanto stabilito nella sezione 25(2-c) della Workers' Compensation Law. Secondo tali programmi istituzionali, fatto salvo situazioni di emergenza, il trattamento iniziale di qualsiasi tipo di infortunio sul lavoro o malattia correlata alla professione Le dovrebbe essere garantito dalle reti di assistenza certificate o dai professionisti/strutture designati dal suo datore di lavoro.

Al datore di lavoro:

Il datore di lavoro è tenuto a fornire al suddetto dipendente, vittima di infortunio sul lavoro, copia firmata del presente modulo e conservare l'originale nei propri archivi per eventuali ispezioni da parte della Workers' Compensation Board. Non convalidare né inviare il modulo alla Workers' Compensation Board fintanto che il dipendente non subisce danni fisici dovuti a infortuni sul lavoro o all'insorgere di malattie correlate alla professione.

La Workers' Compensation Board assume e serve persone affette da disabilità senza alcun tipo di discriminazione.

DECLARACION DE DERECHOS

A TODO EMPLEADO LESIONADO EN EL TRABAJO O QUE SUFRA DE ENFERMEDAD OCUPACIONAL: USTED PUEDE TENER DERECHO A BENEFICIOS DE COMPENSACION OBRERA

1. Usted deberá presentar una reclamación de beneficios dentro del término de dos años del dia en que fue lesionado, a menos que la lesión sea tan pequeña que no requiera tratamiento médico y que no cause interrupción en su jornada de trabajo. Si no radica dentro del término de dos años, puede perder sus derechos a beneficios. Consiga y radique una forma de reclamación (Forma C-3, o VF-3 para bomberos voluntarios, o VAW-3 para empleados voluntarios de ambulancias) en la oficina más cercana de la Junta de Compensación Obrera (direcciones más abajo).
2. Usted tiene derecho a compensación si su lesión relacionada con el trabajo le impide trabajar por más de siete días, le obliga a trabajar a sueldo más bajo ó resulta en incapacidad permanente de cualquier parte de su cuerpo. Usted puede tener derecho a servicios de rehabilitación si necesita ayuda para regresar al trabajo. (Bomberos voluntarios y Trabajadores de Ambulancia Voluntarios pueden ser compensados desde el mismo dia de su lesión.)
3. Usted tiene derecho a recibir tratamiento médico relacionado con su lesión y debe obtenerlo inmediatamente.
4. Para el tratamiento de cualquier lesión o enfermedad relacionada con el trabajo, usted puede escoger cualquier médico, podiatra, quiropractico ó psicologo (si es referido por un médico autorizado) que esté autorizado y acepte pacientes de la Junta de Compensación Obrera. Sin embargo, si su patrono está autorizado a participar en una organización certificada de proveedores preferidos (PPO), usted deberá obtener tratamiento inicial para cualquier lesión o enfermedad relacionada con el trabajo de la correspondiente entidad. Patronos que participen en esta programa establecida por ley estan obligados a proveer a sus empleados notificación escrita explicando sus derechos y obligaciones bajo el programa a que esté acogido.
5. Usted deberá requerir de su Médico que radique copias de los informes médicos de su caso en la Junta de Compensación Obrera y en la compañia de seguros de su patrono, que se indica al final de esta forma.
6. No pague a ningun proveedor médico directamente por tratamiento de su lesión o enfermedad relacionada con el trabajo. Ellos deben enviar sus facturas al asegurador de su patrono. Si el caso es cuestionado, el proveedor deberá esperar hasta que la Junta decida el caso, antes de iniciar gestión de cobro alguna contra usted. Si usted no tramita su caso ó la Junta falla que su lesión o enfermedad no está relacionada con el trabajo, usted podría ser responsable del pago de las facturas.
7. El patrono es responsable de la sustitución y reparación de aquellos implementos médicos que han sido perdidos o se han deteriorado como consecuencia del empleo, sin que importe el que el empleado haya onosufrido lesión (Ej. miembros artificiales, dentadura postiza, espejuelos). Usted tambien tiene derecho a ser reembolsado por medicinas, muletas, o cualquier otro implemento debidamente recetado por su médico y por transportación u otro gasto necesario para ir al médico óalhospital. (Obtenga recibos para justificar gastos.)
8. No es obligatorio el estar representado en ninguno de los procedimientos de la Junta, pero es un derecho que usted tiene, el estar representado por abogado ó por representante licenciado si usted así lo desea. Si es representado, no pague al abogado ó al representante licenciado. Cuando la Junta decida su caso, los honorarios seran determinados por la Junta y descontados de sus beneficios.
9. La compensación se paga inmediatamente, sin esperar por la adjudicación del caso, excepto cuando la reclamación es cuestionada. Si la reclamación es cuestionada en base a que la incapacidad no fue causada por un accidente relacionado con su trabajo ó por una enfermedad ocupacional ó por una lesión en el cumplimiento de su deber como bombero voluntario ó como miembro voluntario del cuerpo de ambulancia, usted puede tener derecho a recibir beneficios por incapacidad (para lesiones fuera del trabajo). Si su reclamación es cuestionada y no está recibiendo beneficios por incapacidad, comuniquese con cualquier oficina de la Junta.
10. Regrese a su trabajo tan pronto pueda. La compensación nunca es tan alta como su sueldo. Si necesita ayuda para regresar al trabajo ó para resolver problemas financieros ó personales por causa de la lesión sufrida, comunicate con la oficina mas cercana de la Junta y solicita hablar con un trabajador social o con un consejero de rehabilitación.
11. Su patrono no puede solicitar que usted le releve de su derecho a compensación, ni puede descontar cantidad alguna de su paga para contribuir al pago de las primas del seguro. Usted no podrá ser despedido ni penalizado por radicar una reclamación en la Junta.

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO Ó TIENE DUDAS SOBRE CUALQUIER SITUACIÓN RELACIONADA CON UNA LESIÓN O ENFERMEDAD COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA.

Este resumen es una compilación de los puntos más importantes de sus derechos bajo la ley de compensación obrera. La sección 110 de la ley requiere de su patrono ofrecerle esta información.

PRESIDENTE
WORKERS' COMPENSATION BOARD

NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

NEW YORK STATE Workers' Compensation Board

Employee Claim

State of New York - Workers' Compensation Board

C-3

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness.Type or print neatly. This form may also be filled out on-line at www.wcb.ny.gov.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: _____/_____/_____

3. Mailing address: _____ (Number and Street/PO Box/Apartment No. / City / State / Zip Code)

4. Social Security Number: ___ - ___ - _____ 5. Phone Number: (____)_____ 6. Gender: ☐ Male ☐ Female

7. Will you need a translator if you have to attend a Board hearing? ☐ Yes ☐ No If yes, for what language? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (____)_____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: _____/_____/_____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: _____/_____/_____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ DATE OF INJURY/ILLNESS: _____/_____/_____
First MI Last

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: _____/_____/_____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? _____/_____/_____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____/_____/_____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? _____/_____/_____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
Name and address where you were first treated: _____
_____ Phone Number: (_____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
Give the name and address of the doctor(s) treating you for this injury/illness: _____
_____ Phone Number: (_____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
_____
_____
_____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: _____/_____/_____

On behalf of Employee: _____ Print Name: _____ Date: _____/_____/_____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: _____/_____/_____

Print Name: _____ Title: _____

ID No., if any: **R** _____ If Licensed Representative, License No.: _____ Expiration Date: _____/_____/_____

NEW YORK STATE | Workers' Compensation Board

Limited Release of Health Information (HIPAA)

State of New York - Workers' Compensation Board

C-3.3

WCB Case No. *(if you know it)*:_____

To Claimant: If you received treatment for a *previous* injury to the same body part or for an illness similar to the one described in your current Claim, fill out this form. This form allows the health care providers you list below to release health care information about your previous injury/illness to your employer's workers' compensation insurer. The federal HIPAA law (Health Insurance Portability and Accountability Act of 1996) says you have a right to get a copy of this form. If you do not understand this form, talk to your legal representative. If you do not have a legal representative, the Advocate for Injured Workers at the Workers' Compensation Board can help you. Call: 800-580-6665.

To Health Care Provider: A **copy** of this HIPAA-compliant release allows you to disclose health information. If you send records to the employer's workers' compensation insurer in response to this release, also mail copies to the Claimant's legal representative. (If no legal representative is listed below, send copies to the Claimant.) Health care providers who release records must follow New York state law and HIPAA.

This release is:

- **Voluntary.** Your health care provider(s) must give you the same care, payment terms, and benefits, whether you sign this form or not.
- **Limited.** It gives your health care provider(s) permission to release only those health records that are related to the previous illness/condition you describe below.
- **Temporary.** It ends when your current claim for compensation is established or disallowed and all appeals are exhausted.
- **Revocable.** You can cancel this release at any time. To cancel, send a letter to the health care provider(s) listed on this form. Also, send a copy of your letter to your employer's workers' compensation insurer and the Workers' Compensation Board. *Note: You may not cancel this release with respect to medical records already provided.*
- **For records only.** It gives your health care provider(s) listed on this form permission to send copies of your health care records to your employer's workers' compensation insurer.

This form does NOT allow your health care provider(s) to release the following types of information:

- **HIV-related information**
- **Psychotherapy notes**
- **Alcohol/Drug treatment**
- **Mental Health treatment** (unless you check below)
- **Verbal information** (your health care providers may not discuss your health care information with anyone)

Any medical records released will become part of your workers' compensation file and are confidential under the Workers' Compensation Law.

A. YOUR INFORMATION (Claimant)

1. Name:_____ 2. Social Security Number:_____-_____-_____
3. Mailing Address: _____
4. Date of Birth: _____/_____/_____ 5. Date of the current injury/illness: _____/_____/_____
6. Current injury/illness, including all body parts injured:_____
   _____
7. Your legal representative's name and address (if any):_____
   _____

☐ *Check here if you allow your health care provider(s) to release **mental health care** information.*

B. YOUR HEALTH CARE PROVIDER(S)

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers attach their contact information to this form.)

1. Provider:_____ 2. Phone Number: (_____)_____
3. Mailing Address: _____
4. Other provider (if any):_____ 5. Phone Number: (_____)_____
6. Mailing Address:_____

C. READ AND SIGN BELOW.

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above.

_____
Claimant's signature (ink only -- use blue ballpoint pen, if possible.) Date

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below:

_____
Your name | Relationship to Claimant | Signature (ink only -- use blue ballpoint pen, if possible.) | Date

Versión en español al reverso de la forma.

NEW YORK STATE | Workers' Compensation Board

Divulgación limitada de información sobre la salud
(HIPAA)

C-3.3

Estado de NuevaYork - Junta de Compensación Obrera (WCB)

WCB Case No. (if you know it) (Número de caso WCB *[si lo sabe]*)

Al reclamante: Si usted recibió tratamiento por una lesión anterior en la misma parte del cuerpo o por una enfermedad similar a la que motiva ahora su reclamación, complete este formulario. Este formulario les permite a los proveedores de salud que usted señala a continuación divulgar a la compañía de seguros de compensación obrera de su empleador la información sobre su salud relacionada con su lesión/enfermedad anterior. La Ley federal HIPAA (Ley de portabilidad y responsabilidad del seguro de salud de 1996) establece que usted tiene derecho a recibir una copia de este formulario. Si no comprende este formulario, hable con su representante legal. Si no tiene un representante legal, el Representante de los obreros lesionados de la Junta de Compensación Obrera puede ayudarlo. Llame al 800-580-6665.

Al proveedor de salud: Una **copia** de esta divulgación, redactada según lo que establece la ley HIPAA, le permite divulgar información sobre la salud. Si envía los registros al asegurador de compensación obrera del empleador en respuesta a la presente divulgación, también debe enviar por correo copias al representante legal del reclamante. (Si a continuación no se especifica un representante legal, envíe las copias al reclamante). Los proveedores de salud que divulgan los registros deben cumplir con las leyes del estado de Nueva York y la HIPAA.

Esta divulgación es:

- **Voluntaria.** Su(s) proveedor(es) de salud deben otorgarle la misma atención, condiciones de pago y beneficios, independientemente de que usted firme este formulario o no.
- **Limitada.** Le otorga a su(s) proveedor(es) de salud permiso para divulgar únicamente los registros médicos que se relacionen con la enfermedad/afección anterior que usted describe a continuación.
- **Temporal.** Termina cuando se otorgue o desestime su actual reclamación de compensación y se hayan agotado todas las apelaciones.
- **Revocable.** Usted puede cancelar esta divulgación en cualquier momento. Para hacerlo, envíe una carta al (a los) proveedor(es) de salud que se indican en este formulario. Además, envíe una copia de su carta a la compañía de seguros de compensación obrera de su empleador y a la Junta de Compensación Obrera. *Nota: No podrá cancelar esta divulgación en lo que se refiere a registros médicos que ya se hayan provisto.*
- **Solamente para registros.** Le otorga a su(s) proveedor(es) de salud que se indica(n) en este formulario permiso para enviar copias de sus registros de salud a la compañía de seguros de compensación obrera de su empleador.

Este formulario NO autoriza a su(s) proveedor(es) de salud a divulgar los siguientes tipos de información:

- **Información relacionada con el VIH**
- **Notas de terapia psicológica**
- **Tratamientos por abuso de alcohol o drogas**
- **Tratamiento de salud mental** (a menos que usted lo indique a continuación)
- **Información verbal** (sus doctores no pueden hablar con nadie sobre su información de salud)

Los registros médicos divulgados se incorporarán a su expediente de compensación obrera y son confidenciales conforme a la Ley de compensación obrera.

CONTESTA LAS SIGUIENTES PREGUNTAS, EN INGLÉS SI ES POSIBLE, EN LOS ESPACIOS PROVISTOS Y FIRMA AL FRENTE DE LA FORMA.

A. YOUR INFORMATION (Claimant) INFORMACIÓN PERSONAL (Reclamante)

1. Name (Nombre)
2. Social Security Number (Número de seguro social)
3. Mailing Address (Dirección postal)
4. Date of Birth (Fecha de nacimiento)
5. Date of the current injury/illness (Fecha de la lesión/enfermedad actual)
6. Current injury/illness, including all body parts injured (Descripción de la lesión/enfermedad actual, incluyendo todas las partes del cuerpo lesionadas)
7. Your legal representative's name and address (if any) (Nombre y dirección de su representante legal [si corresponde])

Check here if you allow your health provider(s) to release ***mental health care*** *information. (Marque aquí si autoriza a su(s) proveedor(es) de salud a divulgar información sobre* ***tratamientos de salud mental****.)*

B. YOUR HEALTH CARE PROVIDERS

(List all health care providers who treated you for a *previous* injury to the same body part or similar illness. If more than 2 providers, attach their contact information to this form.

SU(S) PROVEEDOR(ES) DE SALUD (Enumere todos los proveedores de salud que le han tratado por lesiones previas a las mismas areas del cuerpo ó por enfermedades semejantes.Si son más de 2 proveedores, adjunte su información de contacto a este formulario.)

1. Provider (Proveedor de salud)
2. Phone Number (N° de teléfono)
3. Mailing Address (Dirección postal)
4. Other provider (if any) (Otro proveedor [si corresponde])
5. Phone Number (N° de teléfono)
6. Mailing Adress (Dirección postal)

C. READ AND SIGN BELOW

I hereby request that the health care provider(s) listed above give my employer's workers' compensation insurer copies of all health records related to any previous injury/illness, to all body parts, described above. **LEA Y FIRME A CONTINUACIÓN.** Por la presente solicito que los proveedores de salud aquí enumerados le provean al asegurador de compensación obrera de mi patrono copias de todos los records médicos relacionados a cualquier lesión/enfermedad aquí enumeradas.

If the claimant is unable to sign, the person signing on his/her behalf must fill out and sign below: (**Si el reclamante no puede firmar**, la persona que firme el formulario en su nombre y representación debe llenar y firmar a continuación)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Claimant's signature (Firma del reclamante) use solo tinta - preferiblemente azul | Date (Fecha)

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Your name (Su nombre) | Relationship to Claimant (Relación con el reclamante) | Signature(Firma) | Date(Fecha)

Instructions for Completing Form C-3, "Employee Claim"

Please complete this form and send it to the Workers' Compensation Board centralized mailing address listed at the bottom of these instructions. If you need additional help in completing this form, contact the Workers' Compensation Board at **1-877-632-4996. You may also fill this form out online at: http://www.wcb.ny.gov/**

If you do not have or know your Workers' Compensation Board Case Number, please leave this field blank. It is not required to process your claim. Remember to enter your name and the date of your injury/illness on the top of page two.

Section A - Your Information (Employee):

Item 1: Enter your full name, including first name, middle initial, and last name.
Item 2: Enter your date of birth in month/day/year format. Include the four digit year.
Item 3: Enter your mailing address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Enter your Social Security Number. This is very important to help service your claim faster.
Item 5: Indicate the primary contact phone number, including area code. This may include a cell phone number.
Item 6: Indicate your gender (Male or Female).
Item 7: Board hearings are conducted in English. If you will need a translator to understand the proceeding, the Board will provide one. Check Yes and indicate the language needed.

Section B - Your Employer(s):

Item 1: Indicate the employer you were working for at the time you were injured or became ill.
Item 2: Enter the phone number for this employer, either a primary contact number or the number for your supervisor.
Item 3: Enter the employer's address, including P.O. Box, if applicable, city or town, state, and Zip code.
Item 4: Indicate the date you were hired by this employer.
Item 5: Enter your direct supervisor's name, whom you report to on a regular basis.
Item 6: If you have more than one job, please indicate the names and addresses of all other employers you work for besides the one you were injured at. Please attach a separate sheet if you need more room.
Item 7: Check Yes if you lost time from any of your other jobs as a result of your injury or illness; otherwise, check No.

Section C - Your Job on the Date of the Injury or Illness:

Item 1: Indicate your current job title or job description (e.g., warehouse worker).
Item 2: Indicate your typical work activities for this job (e.g., keeping inventory, unloading trucks, etc.).
Item 3: Check the type of job you had.
Item 4: Enter your gross pay (before taxes) per pay period.
Item 5: Indicate how often you received a paycheck (weekly, bi-weekly, etc.).
Item 6: Indicate if you received any tips or lodging in addition to your regular pay. If you did, describe them.

Section D - Your Injury or Illness:

Item 1: Enter the date when you were injured or the first date you noticed you became ill. Enter the date in month/day/year format. Include the four digit year. If this is an illness or occupational disease, then skip item 2.
Item 2: Enter the time when the injury occurred. Check whether it was AM or PM.
Item 3: Indicate the location where the injury/illness occurred, including the address of the building and the physical location in the building where the injury/illness happened.
Item 4: Check whether this was your normal work location. If it was not, explain why you were at this location.
Item 5: Describe in detail what you were doing at the time of the injury/illness (e.g., unloading boxes from a truck by hand). This explains the events leading up to the injury.
Item 6: Describe in detail how the injury/illness occurred (e.g., I was lifting a heavy box off a truck). This should include all people and events involved in the injury/illness.
Item 7: Indicate fully the nature and extent of your injury/illness, including all body parts injured. Be as specific as possible. (e.g., I strained my back trying to lift a heavy box. It hurts to bend over or hold even lighter objects now.)
Item 8: Indicate if some object was involved in the accident OTHER THAN a licensed motor vehicle. Other objects may include a tool (e.g., hammer), a chemical (e.g., acid), machinery (e.g., forklift or drill press), etc.
Item 9: Indicate if a licensed motor vehicle was involved in the accident. If so, check if the motor vehicle involved was yours, your employer's, or a third party's. Include the license plate number (if known). If your vehicle was involved, fill out the name and address of your automobile liability insurance carrier.
Item 10: Check if you gave your employer or supervisor notice of your injury or illness. If so, indicate who you gave notice to as well as if it was orally or in writing. Include the date you gave notice.
Item 11: Check if anyone else saw the injury happen. If anyone did see it, include their name(s).

Section E - Return to Work:

Item 1: If you stopped working as a result of your work-related injury/illness, check Yes and indicate on what date you stopped working. If you have not stopped working, check No and skip to the next section.

Section E - Return to Work (cont):

Item 2: If you have since returned to work, check Yes. Also indicate on what date you started working again, as well as if you have returned to your Normal Duties or if you are on Limited or Restricted Duty. (If you have not returned to your full pre-injury or illness work duties, then you are on Limited Duty.)

Item 3: If you have returned to work, indicate who you are working for now.

Item 4: Enter your gross pay (before tax pay) per pay period for the job you are working at now. Indicate how often you are receiving a paycheck (weekly, bi-weekly, etc.).

Section F - Medical Treatment for This Injury or Illness:

Item 1: If you did not receive medical treatment for this injury/illness, check None Received and skip to item 5. Otherwise, enter the date you first received treatment for this injury/illness and complete the rest of this section.

Item 2: Check if you were first treated on the job for this injury or illness.

Item 3: Check the location where you first received off site medical treatment for your injury or illness. Include the name and address of the facility as well as the phone number (including area code).

Item 4: If you are still receiving ongoing treatment for the same injury or illness, check Yes and indicate the name and address of the doctor(s) providing treatment as well as the phone number (including area code); otherwise check No.

Item 5: If you believe you already had an injury to the same body part or a similar illness, check Yes and indicate if you were treated by a doctor for this injury or illness. If you were treated by a doctor, indicate the name(s) and address(es) of the doctor(s) whom provided care and **complete and file Form C-3.3 together with this form.**

Item 6: If you had a previous injury or illness, check if your previous injury or illness was work-related. If Yes, check if the injury or illness happened while working for your current employer.

Sign Form C-3 in the place provided for "Employee's Signature on page 2, print your name, and enter the date you signed the form. If a third-party is signing on behalf of the employee, that person should sign on the second signature line. If you have legal representation, your representative **must** complete and sign the attorney/representative's certification section on the bottom of page 2.

What Every Worker Should Do in Case of On-The-Job Injury or Occupational Disease:

1. Immediately tell your employer or supervisor when, where and how you were injured.
2. Secure medical care immediately.
3. Tell your doctor to file medical reports with the Board and with your employer or its insurance carrier.
4. Make out this claim for compensation and send it to the Workers' Compensation Board centralized mailing address. Failure to file within two years after the date of injury may result in your claim being denied. If you need help in completing this form, contact the Workers' Compensation Board at 1-877-632-4996.
5. Go to all hearings when notified to appear.
6. Go back to work as soon as you are able; compensation is never as high as your wage.

Your Rights:

1. Generally, you are entitled to be treated by a doctor of your choice, provided he/she is authorized by the Board. If your employer is involved in a preferred provider organization (PPO) arrangement, you must obtain initial treatment from the preferred provider organization which has been designated to provide health care services for workers' compensation injuries.
2. DO NOT pay your doctor or hospital. Their bills will be paid by the insurance carrier if your case is not disputed. If your case is disputed,
   the doctor or hospital must wait for payment until the Board decides your case. In the event you fail to prosecute your case or the Board decides against you, you will have to pay the doctor or hospital.
3. You are also entitled to be reimbursed for drugs, crutches, or any apparatus properly prescribed by your doctor and for carfares or other necessary expenses going to and from your doctor's office or the hospital. (Get receipts for such expenses.)
4. You are entitled to compensation if your injury keeps you from work for more than seven days, compels you to work at lower wages, or results in permanent disability to any part of your body.
5. Compensation is payable directly and without waiting for an award, except when the claim is disputed.
6. Injured workers or dependents of deceased workers may represent themselves in matters before the Board or may retain an attorney or licensed representative to represent them. If an attorney or licensed representative is retained, his/her fee for legal services will be reviewed by the Board and if approved will be paid by the employer or insurance company out of any compensation benefits due. Injured workers or dependents of deceased workers should not directly pay anything to the attorney or licensed representative representing them in a compensation case.
7. If you need help returning to work, or with family or financial problems because of your injury, contact the Workers' Compensation Board office nearest you and ask for a rehabilitation counselor or social worker.

This form should be filed by sending directly to the address listed below:

New York State Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Customer Service Toll-Free Number: 877-632-4996

Your company's workers' compensation insurance carrier is The New York State Insurance Fund (NYSIF), which has a contract with CVS Caremark, a pharmacy benefits manager (PBM) that offers convenient prescription filling services.

NYSIF has implemented an instant enrollment or "short-fill" service with CVS Caremark. The new service allows injured workers immediate acceptance by any pharmacy in the CareComp pharmacy network administered by CVS Caremark. Although New York law does not require us to provide this benefit, we have elected to provide a limited number of cost-effective medication benefits for new claims filed for **work-related injuries or illnesses** in order to help injured workers get through the first, difficult days after an injury and before the claim is accepted.

When an employee sustains a work-related injury, the form on the other side of this page (Workers' Compensation Temporary Prescription Services ID) may be used to fill prescriptions at any participating pharmacy in the CareComp Network of CVS Caremark . It makes **getting prescriptions for your work-related injury** very easy.

Step 1: Employer fills in:
- Employer's Name
- Policy Number

Step 2: Injured employee fills in his/her:
- Social Security Number
- Date of Injury
- Date of Birth
- Name
- Mailing Address

Step 3: Injured employee brings to pharmacy:
- Completed temporary ID form
- Prescription(s) for work-related injury

Step 4: Within 10 days of the New York State Insurance Fund's confirmation of the accident, the injured employee will receive a packet from CVS Caremark. The packet will contain a permanent ID card that should be used when filling prescriptions for the work-related injury.

Note: Injured workers can quickly find local participating pharmacies by visiting: **http://www.wcrxpharmacylocator.com** or by calling the CVS Caremark 24-hour patient care hotline at 1-866-493-1640.

If you have any questions about this form, please contact NYSIF, your workers' compensation carrier, at 1-888-875-5790.

NYSIF New York State Insurance Fund

CVS CAREMARK

Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION **INJURED WORKER**

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact CVS Caremark Customer Service at 1-866-493-1640.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de CVS Caremark, en el teléfono 1-866-493-1640.

Pharmacist/Employer – When form is completed, fax to CVS Caremark: **1-866-493-1644**

Claimant information will be added by CVS Caremark to allow medications to process. This information can also be phoned in at 1-866-493-1640

New York State Insurance Fund	**Group#: NYSIF**
Attention: All items below must be completed.	
EMPLOYER'S NAME: _____	INJURED WORKER'S NAME: _____ FIRST MI LAST:
EMPLOYER's WORKERS' COMPENSATION POLICY NUMBER: _____ DATE OF INJURY: __ __ / __ __ / __ __ __ __ MM / DD / CCYY INJURED WORKER'S DATE OF BIRTH: __ __ / __ __ / __ __ __ __	INJURED WORKER'S MAILING ADDRESS: _____ STREET: _____ CITY, STATE ZIP
ID#: _____ Injured Worker's Social Security Number	*Help Desk: This is a POS Program through CVS Caremark only. For Assistance call the CVS Caremark Help Desk at: 866.493.1640*

Attention Pharmacist:

New York State Insurance Fund's prescription program is administered by CVS Caremark. The following are the steps necessary to submit a prescription for New York State Insurance Fund claimants.

Please follow the action steps listed below to enter the claim.

Step 1	Enter Bin Number 610235
Step 2	Enter PCN: WRK
Step 3	ID: Injured Worker' Social Security Number

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim, please call the CVS Caremark Help Desk at **1-866-493-1640.**

NYS Insurance Fund (NYSIF) - Diagnostic Tests and Examinations

NYSIF has recently sent a letter to all Injured Workers that now have or have had a Workers' Compensation Claim.

No response is necessary.

The purpose of the letter is to inform all Injured Workers that NYSIF has partnered with 4 Network Providers:

SPREEMO IPA, LLC (800-595-7173)

Atlantic Imaging Group IPA, LLC (888-340-5840)

Medfocus Radiology Network (800-398-8999)

OCM IPA, LLC (800-872-2875)

The above NYSIF Network Providers must be contacted by you or your physician's office to schedule MRI's, CT scans and other tests when your physician has requested and NYSIF has approved.

These Network Providers have contracts with many Hospitals and Imaging Centers throughout NYS and the country so there would not be travel involved.

NYSIF, with this notification, has advised you that you **MUST** use one of the above Network Providers for testing over $1000. If you do not use the above Network Providers, NYSIF could deny payment and you or your physician would be responsible for the cost of the tests. You would not have to use a Network Provider under the following circumstances:

a. Network Provider can't schedule testing within 5 days.
b. NYSIF is controverting (not accepting) your claim.
c. In a medical Emergency
d. For X-rays during an office visit used for diagnosis and treatment of fractures etc.

DOCUMENTATION FOR WORKERS' COMPENSATION LEAVE

- Medical documentation must be submitted to the facility Medical Information Officer, not facility medical staff.
- Initial medical documentation for Workers' Compensation must be submitted to the facility Medical Information Officer within the first week of absence or upon return to duty, whichever occurs first.
- For Workers' Compensation absences, documentation is to be submitted to the facility Medical Information Officer on an ongoing basis, normally every 30 days but not less than once every 45 days for extended absences.
- Conforming medical documentation must be submitted to the facility Medical Information Officer UPON RETURN TO DUTY, unless otherwise ordered to return to full or limited duty because of an Independent Medical Evaluation.

Employee's Name: _____

Date of Injury: _____

Date of First Treatment for this Injury: _____

Date of Examination: _____

Date Employee is Incapacitated From: _____ To: _____

Prognosis:

_____

Diagnosis: (Required for all Workers' Compensation absences, regardless of length)

_____
(International Classification of Diseases or ICD Codes are not acceptable)

Re-Evaluation Date: _____ and/or Full Duty Date: _____

☐ This Injury/Illness is Work – Related (Workers' Compensation)

_____
Signature of Medical Provider or Designee

Date Signed: _____

Location of Office Where Examination Took Place:

_____
_____
_____

An alternate form may be used for documentation but all of the required information must be included. All documentation is subject to verification.

ESTIMATED PHYSICAL CAPABILITIES FORM FOR NEW YORK STATE EMPLOYEES

Name of Physician	Name of Employee

Note: Important Information on Reverse

STRUCTIONS: ***If the employee is found to be 50% or less disabled, please complete this form based on your estimation of his/her current physical capabilities.***

1. Medical Diagnosis: _____

2a. In an eight-hour workday, how many hours can this employee: (*Please check appropriate boxes.*)

Sit	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests
Stand	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests
Walk	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ Continuously	☐ With Rests

b. In a given day, for how many total hours can this employee sit, stand, and/or walk in combination?

☐ 4 ☐ 6 ☐ 8 ☐ 10 ☐ 12 ☐ 14 ☐ 16

3. Other Capabilities: (*Please check appropriate boxes.*)

	Never	Occasionally	Frequently	Continuously
Lift				
00–10 lbs.	☐	☐	☐	☐
11–20 lbs.	☐	☐	☐	☐
21–50 lbs.	☐	☐	☐	☐
51–100 lbs.	☐	☐	☐	☐
Carry				
00–10 lbs.	☐	☐	☐	☐
11–20 lbs.	☐	☐	☐	☐
21–50 lbs.	☐	☐	☐	☐
51–100 lbs.	☐	☐	☐	☐
and	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Climb	☐	☐	☐	☐
Run	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate a motor vehicle	☐	☐	☐	☐

Upper Extremities:

Which hand is dominant? ☐ Right ☐ Left

Can this employee perform repetitive actions such as:

	Simple Grasping	Pushing & Pulling	Fine Manipulation
RIGHT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
LEFT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Lower Extremities:

Use of feet/legs for repetitive movement, as in operation of foot controls and motor vehicles.

Right Extremity	Left Extremity	Simultaneous
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Work Environment Restrictions:
   - Can this employee:
     - Be exposed to marked changes in temperature and humidity? ☐ Yes ☐ No
     - Be exposed to unprotected heights? ☐ Yes ☐ No
     - Be around moving machinery? ☐ Yes ☐ No
5. Other Restrictions:
   - Can this employee restrain combative clients? ☐ Yes ☐ No
   - Does this employee have any visual or hearing impairment requiring accommodation? ☐ No ☐ Yes *If "Yes," please explain:* _____

6. Based on your examination(s) of this employee, are there any known problems of a general nature, including any medications prescribed for the diagnosis listed, that would interfere with this employee returning to work?
   ☐ No ☐ Yes *If "Yes," please explain:* _____

When, in your estimation, will this employee be ready to return to full duty? Date_____

Comments: _____

Physician's Signature	Telephone Number	Date
	( )	

(2/96)

INDEPENDENT MEDICAL EXAM (IME)

This is to remind all members who are ordered to go to an Independent Medical Exam by the insurance company to bring someone with them to either videotape or record the exam.

If you miss the IME or reschedule your benefits under 14.9 Workers compensation leave can be stopped. Please refer to the workers compensation benefit election form and the MOU. By selecting the workers' compensation leave benefit program you agree to participate in the medical evaluation and limited duty components of the program.

MEDICAL TREATMENT GUIDELINES FOR WORK-RELATED INJURIES BECAME EFFECTIVE ON DECEMBER 1, 2010

Providers must follow the Medical Treatment Guidelines for the following parts of the body:

- **Knee**
- **Shoulder**
- **Low and mid back**
- **Neck**

The guidelines were developed as a result of the WC reform legislations signed into law in 2007. Paperwork the provider needs to file with the State Insurance Fund and the Workers' Compensation Board changed on December 1, 2010. As a result, you may not have to wait for the State Insurance Fund to authorize an MRI, physical therapy and some surgeries.

More information is available on the WCB website: **www.wcb.ny.gov**

Get the Facts about Medical Treatment Guidelines

For injuries to the **Neck, Back, Shoulder, and Knee**

There are lots of MYTHS about the *Guidelines*.
Protect your rights — get the FACTS!

The Medical Treatment Guidelines provide the best treatment available if you injure your neck, back, shoulder, or knee while working.

In addition, when your doctor uses the *Guidelines*, it ensures you will get the treatment you need quickly.

- **MYTH:** I will not be able to get the treatment I need as a result of the new *Guidelines*. **FACT:** Wrong! The *Guidelines* are designed to help you get the best medical care for your injury. They were created by doctors who specialize in treating people just like you — people who have been injured at work.
- **MYTH:** The *Guidelines* do not allow for exceptions that I may need. **FACT:** The *Guidelines* are designed to be flexible. They recognize that all treatments are not appropriate for everyone.

  The *Guidelines* allow your doctor to request permission to use a different approach for your care.
- **MYTH:** If I have a flare-up or my condition gets worse, I won't be able to get medical care. **FACT:** You will be able to get the treatment you need. The *Guidelines* won't keep you from getting necessary medical care if your injury gets worse or flares up.
- **MYTH:** I won't be able to get physical therapy, chiropractic treatment, or acupuncture. **FACT:** The *Guidelines* recommend the use of physical therapy, chiropractic treatment, and acupuncture. It's important for your doctor to show that the treatment is helping you get better. If the treatment is not helping, your doctor and you need to find a treatment that will help.
- **MYTH:** I will only be able to get pain medicine during the first weeks of injury. **FACT:** The *Guidelines* will not keep your doctor from ordering appropriate pain medicine.

  In most cases, injured workers need prescription pain medicine for only a short time. If you still have pain, talk with your doctor. Your doctor may continue to prescribe pain medicine but to do so, he or she must explain why it is medically necessary for you to continue to take them.

  The *Guidelines* are designed to help your doctor balance the goals of getting you better, relieving your pain, and preventing harm.
- **MYTH:** Workers' Compensation no longer pays on-going medical benefits for my injury. **FACT:** The

Guidelines do not change your basic rights under Workers' Compensation law; you still have the right to receive necessary medical care when you are injured while working.

Medical costs will be paid provided your doctor continues to follow the *Guidelines*.

- **MYTH:** The purpose of the *Guidelines* is to limit care and reduce costs. **FACT:** The main goal of the *Guidelines* is to ensure you receive the highest quality medical care as quickly as possible — so you can get better and return to work. Overall costs go down when injured workers get timely, quality care.
- **MYTH:** It will take much longer for me to get the treatment I need. **FACT:** With the new *Guidelines*, most treatments require no prior-authorization. That means when your doctor uses the *Guidelines*, you can get the treatment you need even faster!

Get the Best Treatment

The new *Guidelines* were created to ensure you get the best medical care for your injury. So you can get well. So you can get back to work. So you can get on with your life!

Developed by Doctors

The *Guidelines* were developed based on input from expert doctors around the country who specialize in helping people like you: people who have been injured on-the job.

Evidence Based

The *Guidelines* are evidence based - that means they are supported by the strongest scientific data available.

No Red Tape

The *Guidelines* were also designed to reduce red-tape. Most of the treatments recommended by the *Guidelines* are pre-approved. That means less time waiting for treatment — so you can start feeling better sooner!

Dispute Resolution Program

New York State Workers' Compensation Program

For NYS Employees represented by:

- **New York State Correctional Officers and Police Benevolent Association, Inc. (NYSCOPBA) in the Security Services Unit**
- **Council 82 in the Security Supervisors Unit**
- **Police Benevolent Association of New York State, Inc. (PBANYS) in the Agency Police Services Unit (APSU)**

Administered by:

National Medical Reviews, Inc.
607 Louis Drive, Suite C
Warminster, PA 18974
Phone: 215-352-7800/Toll free: 800-283-8196
Fax: 215-352-7801/Toll free: 866-357-9045

What is the Medical Evaluation Program (MEP)?

The Medical Evaluation Program (MEP) is a program that provides eligible employees who suffer a work-related injury or illness with an expedited, independent examination arranged by the New York State Insurance Fund (SIF). A SIF Evaluating Physician will determine your degree of disability. This determination is used by your Employing Agency as the basis for its decision to make a Light Duty Assignment.

What is the Dispute Resolution Program (DRP)?

The Dispute Resolution Program (DRP) provides eligible employees with a process to review conflicting medical opinions regarding your degree of disability for a work-related injury or illness.

The DRP affords you the opportunity for an independent, third party medical review, in those instances where the decision of the Evaluating Physician does not agree with your Treating Physician regarding your degree of disability.

What is the effect of the Evaluating Physician's determination on the MEP?

If the Evaluating Physician determines that your degree of disability is greater than fifty percent (50%), you continue to receive workers' compensation leave benefits at full-pay.

If the Evaluating Physician determines that your degree of disability is fifty percent (50%) or less, the Evaluating Physician must also assess your estimated physical capabilities and expected return to work.

When did the DRP become effective?

A work-related injury or illness that occurred on or after April 15, 1993 and was in dispute regarding the degree of disability on or after November 1, 1998 is eligible for the DRP.

Who performs the third party medical review?

National Medical Reviews, Inc. (NMR), an independent medical review organization dedicated to providing evidenced-based medical reviews, will issue an independent, third party review determination regarding your degree of disability.

Dispute resolution reviews are conducted by physicians selected from NMR's extensive panel of

more than five hundred (500) physicians representing twenty six (26) medical disciplines. NMR physicians, who are board certified in their specialties and authorized by the New York State Workers' Compensation Board (Board), will evaluate your medical records. Assignments for appeals will be made according to the specific type of injury or illness involved. For example, heart diagnoses will be reviewed by a cardiologist, surgical diagnoses by a surgeon, etc.

NMR assures that appeals are reviewed by members of a neutral panel of physicians. These physicians must adhere to NMR's confidentiality and conflict of interest requirements. A Reviewer must maintain the confidentiality of the personal health information provided and must decline to review any case where he/she has been involved personally or professionally.

Which cases are eligible for dispute resolution?

Your case is eligible for dispute resolution if you have elected to participate in the MEP, and

a. your Treating Physician determines that you have an injury/illness resulting in a disability of greater than fifty (50) percent and the Evaluating Physician determines that you have an injury/illness resulting in a disability of fifty (50) percent or less; or

b. your Treating Physician determines that a disability exists and the Evaluating Physician determines you have no disability.

In either of these situations, if your Treating Physician's determination does not agree with the Evaluating Physician's determination, your Treating Physician may appeal on your behalf.

Who can initiate the request for dispute resolution?

Requests for dispute resolution must be initiated on your behalf by your Treating Physician using a Dispute Resolution Program Appeal Form (Appeal Form). You can obtain this Appeal Form from your Employing Agency.

You are responsible for providing the Appeal Form to your Treating Physician, informing him/her of the appeal process and requesting that he/she submit the appeal to NMR.

Your Treating Physician is responsible for providing NMR with a completed Appeal Form and all medical documentation to substantiate the degree of disability determination.

The Evaluating Physician's report will be provided by the SIF to NMR if it was not received from your Treating Physician.

When must the Treating Physician submit the appeal to NMR?

Your Treating Physician must submit the appeal to NMR during the Appeal Period. For the MEP, the Appeal Period is three (3) business days from the time that you are notified to return to work. Business day means any day Monday through Friday, with the exception of holidays observed by the State as an employer.

The time of day that you receive your notification is important in determining the first day of the Appeal Period. If your notification to return to work occurs prior to noon, that is the first day of the Appeal Period. If the notification occurs at noon, afternoon or on a non-business day, the next business day is the first day of the Appeal Period.

What time frames must be followed by NMR?

When NMR receives your appeal, NMR must immediately request supporting medical documentation from the Evaluating Physician (if it was not received from your Treating Physician). Once NMR receives complete medical documentation from both the Treating and Evaluating Physicians, NMR will complete the review within seven (7) calendar days. This seven-day period is the Program Review Period. NMR will report, in writing, the Reviewing Physician's decision to uphold the Treating or Evaluating Physician's determination within the Program Review Period. The outcome of the review shall be reported in writing to you, your Employing Agency, your Treating Physician, the Evaluating Physician, your bargaining unit and the SIF.

What are the consequences of missing a deadline?

a. If your Treating Physician's appeal including all necessary medical documentation is not received by NMR within the Appeal Period, and you do not return to work from the work-related injury or illness, you will remain in or be placed in Leave Without Pay (LWOP) status until an appeal is received.

b. If NMR's decision is not completed within the Program Review Period and you had a work-related injury or illness, you (either working, on LWOP or charging accruals) will be placed in Workers' Compensation Leave full-pay status on the next assigned work day until NMR's decision is rendered.

What is the payroll status of employees during the Appeal Process?

a. If you return to work in a light duty, modified duty or full duty assignment pending the outcome of an appeal, you will receive full-pay.

b. If the three days of LWOP ends prior to the expiration of the Appeal Period [three (3) business days], you will be allowed to use leave credits until the Appeal Period expires.

c. Following the three days of LWOP and if your appeal is received by NMR during the Appeal Period, you will be allowed to charge available leave credits for the number of days in the Program Review Period [up to seven (7) calendar days] pending the outcome of the appeal.

What happens if the NMR Physician finds in favor of the Treating Physician?

If NMR finds in favor of your Treating Physician's determination of your degree of disability, your Employing Agency will advise you through a telephone call and letter not to report to work until further notification. The appropriate Workers' Compensation Leave will be retroactive to the first day of LWOP relating to the disputed degree of disability for a work-related injury or illness.

What happens if the NMR physician finds in favor of the Evaluating Physician?

If the NMR physician finds in favor of the Evaluating Physician's determination of degree of disability, your Employing Agency will notify you to report to work in a medically appropriate assignment. If you fail to report to work, you will be placed in LWOP status. Any leave credits used during the Appeal Period and/or Program Review Period will not be returned to you. The period of Workers' Compensation Leave without charge to credits will not be affected by an adverse decision in the DRP. If, at a subsequent hearing of the Board, the Appeal Period or Program Review Period is found compensable, restoration of such leave credits will be proportional to the wage award.

Once you are notified by NMR of the Reviewing Physician's determination, there is no further appeal under the DRP. Requests for further appeals beyond the DRP pertaining to issues of eligibility for statutory benefits must be made to the Board pursuant to the New York State Workers' Compensation Law.

What happens after the appeal is filed?

In addition to the Dispute Resolution Program Appeal Form, there are two letters you will receive as part of the dispute resolution process:

Acknowledgment letter advising you that the appeal was received by NMR and that all medical documentation was included. If all medical documentation was not received, your appeal will be considered invalid. The appeal cannot be reviewed until NMR receives the necessary medical documentation.

Review Determination letter advising you of the outcome of your appeal. The NMR Reviewing Physician will either agree with your Treating Physician or agree with the Evaluating Physician on your degree of disability.

You will be contacted by your Employing Agency regarding the outcome of the review.

How do I initiate an appeal through the DRP?

- ☐ Obtain the New York State Workers' Compensation Dispute Resolution Program Appeal Form from your Employing Agency immediately upon receiving the notification by your Employing Agency to return to work.
- ☐ Complete the form by printing or typing all requested information in Part I, Employee Section of the Appeal Form.
- ☐ Sign your name at the bottom of Part I.
- ☐ Immediately take the form to your Treating Physician.
- ☐ Explain to your Treating Physician the importance of completing Part II of the form and submitting it to NMR **within three (3) business days of notification by your Employing Agency to return to work.** Failure to comply may result in additional leave without pay.

NOTE: You cannot file this appeal on your own behalf. Only your Treating Physician can file this appeal.

Instructions to Treating Physician:

- ☐ Type or print all requested information in Part II of the Appeal Form.
- ☐ Attach all additional medical documentation needed to substantiate the employee's degree of disability to the completed Appeal Form.
- ☐ Sign your name at the bottom of Part II.
- ☐ Send the completed Appeal Form and any additional medical documentation to NMR by overnight mail or facsimile **within (3) business days of notification by the Employing Agency to the employee to return to work.** Any information sent via facsimile should be followed with a copy by mail.
- ☐ NMR mailing address:

  National Medical Reviews, Inc.
  607 Louis Drive, Suite C
  Warminster, PA 18974
  Phone: 215-352-7800 / Toll free: 800-283-8196
  Fax: 215-352-7801 / Toll free: 866-357-9045

- ☐ You will receive a copy of the NMR physician's determination which will agree with either your determination or that of the Evaluating Physician in regard to the Employee's degree of disability.

The Department of Civil Service, the State Insurance Fund and the Workers' Compensation Board administer the Workers' Compensation Program.

State of New York, Department of Civil Service

Employee Benefits Division

Agency Building 1

Empire State Plaza

Albany, NY 12239

WC/DRP/2-17

It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. If you need an auxiliary aid or service to make benefits information available to you, please contact your Personnel Office.

New York State Workers' Compensation
Dispute Resolution Program Appeal Form
For Employees Eligible for the Medical Evaluation Program (MEP)

Instructions to Employee: Complete Part I of this form and immediately take it to your Treating Physician who must complete Part II. Your Treating Physician must return this form to National Medical Reviews, Inc. (NMR) within three (3) business days of notification by your Employing Agency to return to work. Failure to comply may result in leave without pay status. **You cannot file this appeal on your own behalf; this appeal form must also be completed and submitted to NMR by your Treating Physician.**

Part I: To be completed by Employee (Please print or type)

Date	Date Notified to Return to Work
Employee Name (first, middle, last)	Social Security Number
Home Address	Home Telephone Number
	SIF Carrier Case Number (Eleven digits) _____-_____
Employing Agency Name	Work Address
Work Phone Number	
Date and brief description of the injury/illness resulting in your Workers' Compensation claim: (ATTACH ADDITIONAL SHEETS)	
Employee Signature	Negotiating Unit (NU): NU Code:

Part II: To be completed by Employee's Treating Physician (Please print or type)

Instructions to Treating Physician: Complete Part II of this form and immediately return it with complete and comprehensive medical documentation that substantiates the employee's degree of disability. A NMR Physician will review the medical records and documentation sent by you and the Evaluation Physician and will render a determination in regard to the degree of disability that agrees with your determination or that of the Evaluation Physician. NMR must receive this completed form (including all necessary medical documentation) within three (3) business days of notification by the Employing Agency to the employee to return to work. Failure to comply may result in leave without pay status for the employee. **You may mail or fax completed forms and supporting documentation to:**

National Medical Reviews, Inc.
607 Louis Drive, Suite C
Warminster, PA 18974
Fax: (215) 352-7801 / Toll Free (866) 357-9045
Phone: (215) 352-7800 / Toll Free (800) 283-8196

Please follow all faxed copies with a copy by mail or overnight delivery.

Diagnosis: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]
Treatment Plan: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]
Prognosis: [ATTACH ADDITIONAL MEDICAL RECORD DOCUMENTATION]
Estimated Degree of Disability:_____%

Treating Physician's Signature of Attestation:	Address:
Name: (Please print)	Telephone Number: ( )

New York State Correctional Officers & Police Benevolent Association, Inc.
102 Hackett Blvd., Albany, NY 12209
(518) 427-1551 www.nyscopba.org nyscopba@nyscopba.org

Date:

Dear Dr.

We have discussed the results of the **IME opinion** regarding my disability and return to work ability as well as **your opinion** about my disability and return to work ability.

The Dispute Resolution Program (DRP) provides an opportunity for a review of conflicting medical opinion regarding the above. This process includes a **RECORD** review of the recent IME and your current medical opinion.

It is very important to complete this process within 3 days. I will be on **leave without pay** until National Medical Review (NMR) receives the necessary paperwork from you.

In order to be successful, it is extremely important that **ALL** medical reports from **ALL** treating providers, including a current narrative report, be sent to National Medical Review (NMR). The report should state treatment/testing results, medication and up to date range of motion, if applicable.

The DPR appeal form is attached for completion.

Thank you in advance for your help and cooperation moving my claim toward some resolution.

Sincerely,

New York State Correctional Officers & Police Benevolent Association, Inc.

GRIEVANCE FORM

(Please Type or Print)

Revised: March 1, 2003

LOCAL Grievance Number:_____

Facility (or Agency):_____Greene CF_____

Aggrieved Employee:_____John Doe_____

LOCAL Union Rep:_____Bob Smith, CSS_____

DO NOT WRITE IN THIS BOX

NYSCOPBA Grievance Number: CON_____

Phone Number/ext.____800-555-0000_____

Date Submitted:____1/1/2019__

Date of Occurrence:__12/31/2018_

Contract Article Violation(s):_____14.9 (WC leave)_____

STATEMENT OF FACTS:_____On January 1, 2019, I filed a workers' compensation cla[illegible]or a job-[illegible]ated injury I sustained on December 31, 2018. (A copy of the accident report is attached). On January 1[illegible]019 I [illegible]s informed by facility management that my workers' compensation case (No.87654321) had been controverted by t[illegible]ate Insura[illegible]e Fund (a copy of my notification is also attached). Effective January 16, 2019, my absence from work [illegible]l be cha[illegible]d to my leave time accruals.

REMEDY SOUGHT:____To be restored to Workers'Compensation leave immediately and restoration of all leave accruals used and any salary lost during the period of absence necessitatied by my injury.

Aggrieved Employee's Signature: John Doe

New York State Correctional Officers & Police Benevolent Association, Inc.

GRIEVANCE FORM

(Please Type or Print)

Revised: March 1, 2003

LOCAL Grievance Number:_____

Facility (or Agency):_____

Aggrieved Employee:_____

LOCAL Union Rep:_____

DO NOT WRITE IN THIS BOX

NYSCOPBA Grievance Number: CON_____

Phone Number/ext._____

Date Submitted:_____

Date of Occurrence:_____

Contract Article Violation(s):_____

STATEMENT OF FACTS:_____

REMEDY SOUGHT:_____

Aggrieved Employee's Signature:_____

STEP I DECISION

Date Received:_____ Date of Review:_____

Superintendent or Designee:_____ Date Answered:_____

Received by (Union Official):_____ Date Received:_____

APPEAL TO STEP II

FACTS OF APPEAL:_____

Signature:_____ Date Appealed:_____

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S RECORD OF MEDICAL AND TRAVEL EXPENSES AND REQUEST FOR REIMBURSEMENT

CLAIMANT'S NAME	WCB CASE NO.	SOCIAL SECURITY NO.
RESIDENTIAL ADDRESS	MAILING ADDRESS (IF DIFFERENT)	

In connection with the above workers compensation case, you are entitled to be reimbursed for (1) drugs, crutches or any apparatus properly prescribed by your doctor and for (2) fares, automobile mileage or other necessary expenses going to and from your doctor's office or the hospital.

To help you keep a record of such expenses we have provided this form. In order to help insure that you are properly reimbursed, list each item of expense below--whether or not you obtained a receipt (wherever possible obtain receipts). **Submit the completed form and copies of all receipts or bills to the workers' compensation insurance carrier (or to your employer, if self-insured) and to the Workers' Compensation Board.** (See Board address on reverse.) It is suggested that you retain a copy of the receipts and bills for your records.

En relación con el caso de compensación para trabajadores antes mencionado, usted tiene derecho a recibir un reembolso por (1) medicamentos, muletas o cualquier aparato indicado como corresponde por su médico y (2) tarifas, millaje de automóvil u otros gastos necesarios para trasladarse desde y hasta el consultorio de su médico u hospital.

Le proporcionamos este formulario para ayudarlo a llevar un registro de esos gastos. Con el objetivo de garantizar que usted reciba el reembolso correspondiente, enumere cada ítem de gasto a continuación, tenga o no un recibo por ese gasto (siempre que sea posible, intente obtener un recibo). Envíe el formulario completo y copias de todos los recibos o facturas a la compañía de seguros de compensación para trabajadores (o a su empleador en caso de que tenga un seguro propio) y a la Junta de Compensación para Trabajadores (*Workers' Compensation Board*). Le sugerimos que guarde una copia de los recibos y facturas para sus registros.

NATURE OF EXPENSE / TIPO DE GASTOS	DATE / FECHA	AMOUNT / CANTIDAD

Continue on Reverse. - Sigue al dorso.

NATURE OF EXPENSE / TIPO DE GASTOS	DATE / FECHA	AMOUNT / CANTIDAD

NYS Workers' Compensation Board
Centralized Mailing
PO Box 5205
Binghamton, NY 13902-5205

Travel Reimbursement Rates

Effective Date	Rate (Cents per mile)
1/1/2019	58
1/1/2018	54.5
1/1/2017	53.5
1/1/2016	54
1/1/2015	57.5
1/1/2014	56
1/1/2013	56.5
1/1/2012	55.5
7/1/2011	55.5
1/1/2011	55
1/1/2010	50
1/1/2009	55
7/1/2008	58.5
1/1/2008	50.5
1/1/2007	48.5
1/1/2006	44.5
9/1/2005	48.5
1/1/2005	40.5
1/1/2004	37.5
1/1/2003	36
1/1/2002	36.5
1/1/2001	34.5
1/1/2000	32.5

LAWS OF NEW YORK, 2003

CHAPTER 577

AN ACT to amend the civil service law, in relation to leaves of absence by reason of disability resulting from an assault sustained in the course of or arising out of employment

Became a law September 22, 2003, with the approval of the Governor. Passed by a majority vote, three-fifths being present.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Section 71 of the civil service law, as added by chapter 790 of the laws of 1958, is amended to read as follows:

§ 71. Reinstatement after separation for disability. Where an employee has been separated from the service by reason of a disability resulting from occupational injury or disease as defined in the workmen's compensation law, he or she shall be entitled to a leave of absence for at least one year, unless his or her disability is of such a nature as to permanently incapacitate him or her for the performance of the duties of his or her position. Notwithstanding the foregoing, where an employee has been separated from the service by reason of a disability resulting from an assault sustained in the course of his or her employment, he or she shall be entitled to a leave of absence for at least two years, unless his or her disability is of such a nature as to permanently incapacitate him or her for the performance of the duties of his or her position. Such employee may, within one year after the termination of such disability, make application to the civil service department or municipal commission having jurisdiction over the position last held by such employee for a medical examination to be conducted by a medical officer selected for that purpose by such department or commission. If, upon such medical examination, such medical officer shall certify that such person is physically and mentally fit to perform the duties of his or her former position, he or she shall be reinstated to his or her former position, if vacant, or to a vacancy in a similar position or a position in a lower grade in the same occupational field, or to a vacant position for which he or she was eligible for transfer. If no appropriate vacancy shall exist to which reinstatement may be made, or if the work load does not warrant the filling of such vacancy, the name of such person shall be placed upon a preferred list for his or her former position, and he or she shall be eligible for reinstatement from such preferred list for a period of four years. In the event that such person is reinstated to a position in a grade lower than that of his or her former position, his or her name shall be placed on the preferred eligible list for his or her former position or any similar position. This section shall not be deemed to modify or supersede any other provisions of law applicable to the re-employment of persons retired from the public service on account of disability.

§ 2. This act shall take effect immediately.

EXPLANATION--Matter in italics is new; matter in brackets [-] is old law to be omitted.

The Legislature of the STATE OF NEW YORK ss:

Pursuant to the authority vested in us by section 70-b of the Public Officers Law, we hereby jointly certify that this slip copy of this session law was printed under our direction and, in accordance with such section, is entitled to be read into evidence.

JOSEPH L. BRUNO
Temporary President of the Senate

SHELDON SILVER
Speaker of the Assembly

BILL NUMBER: S5472

SPONSOR: VELELLA

TITLE OF BILL: An act to amend the civil service law, in relation to leaves of absence by reason of disability resulting from an assault sustained in the course of or arising out of employment

PURPOSE OR GENERAL IDEA OF BILL: This bill would protect workers if the injury or disease as defined in the workers' compensation law is sustained by assault during the course of his or her duties, that employee should be eligible for a leave of absence for at least two years, if necessary, unless permanently disabled.

SUMMARY OF SPECIFIC PROVISIONS: Section 1: Section 71 of the civil service law is amended to increase the leave of absence by an employee because of an injury by assault from one year to at least two years leave of absence. Section 2: Effective date.

JUSTIFICATION: Often times, employees working in close proximity with the public are assaulted during the performance of their duties. Currently, Section 71 of the civil service law allows an employee a one-year leave of absence as a result of an injury or disease defined in the workers' compensation law. This bill would increase the length of time to at least two years leave of absence if that employee is injured by an assault on the job.

PRIOR LEGISLATIVE HISTORY: New bill.

FISCAL IMPLICATIONS: None.

EFFECTIVE DATE: Immediately.

NEW YORK STATE
DEFERRED COMPENSATION PLAN
(NYSDCP)

Deductions will be stopped while an employee is paid Workers' Compensation benefits. Employees will become eligible to participate in the NYSDCP upon their return from workers' compensation leave but will need to contact the NYSDCP to re-enroll in the program. (1-800-422-8463).

Under IRS regulations, workers' compensation-related benefits are exempt from Social Security and Medicare taxes. Workers' compensation-related benefits are also exempt from federal income taxes, New York State income taxes and local income taxes, if applicable.

Also, under IRS regulations, non-taxable workers' compensation-related benefits are not eligible for salary deferral under NYSDCP.

If deductions are taken out of the worker's compensation benefit for deferred compensation, a refund of those monies will be returned to the employee in approximately 3 pay periods. Employees may receive a1099-R and letter detailing the amount of the base contribution as well as the gains/losses attributed to those monies. The base contribution is not taxable; however, the gains are not.

Payroll Bulletin

Office of the State Comptroller
Bureau of State Payroll Services

Date: April 12, 2017 **Bulletin Number: 1564**

Subject New York State Deferred Compensation Plan (NYSDCP) Refunds for Employees on Workers' Compensation

Purpose To notify agencies of the automatic processing of refunds for deferred compensation contributions in a current calendar year pay check for which an employee was later placed on workers' compensation leave.

Affected Employees Active employees in Company "NYS" who, in the current year, contributed earnings to a deferred compensation account and those earnings were later determined to be paid workers' compensation benefits.

Background Under IRS regulations, paid workers' compensation benefits are not taxable and cannot be directed to a tax deferred NYSDCP account. (See Payroll Bulletin 1366 for more information.) If an employee is placed on workers' compensation leave for a period of time in which they have already contributed to the NYSDCP, those contributions must be refunded to the employee.

Effective Date(s) Institution paychecks dated April 27, 2017
Administration paychecks dated May 3, 2017

Agency Actions When an agency places an employee on Workers' Compensation Leave, the agency must notify the employee that any contributions made to the NYSDCP for the period the employee is on Workers' Compensation Leave will be refunded to the employee.

OSC Actions

Current Year Refunds for Active Employees

Current year NYSDCP contributions for affected employees with a Job Status of Active, Paid Leave or Leave will be refunded through PayServ. OSC will automatically calculate deferred compensation contribution refunds in paychecks for active employees who were later placed on workers' compensation leave in the current calendar year. Prior to processing the refund, OSC will submit a refund file to Nationwide, the NYSDCP provider, for account balance validation. If the original employee record is inactive, but another record is active, the refund will be processed on the original record.

Prior Year Refunds and Refunds for Inactive Employees

Prior year NYSDCP contributions and current year refunds for affected employees with a Job Status of Retired, Terminated or Deceased and no other active Job record will be refunded by Nationwide, the NYSDCP provider. Nationwide will also provide this population of employees with a Form 1099-R at the end of the calendar year.

Paycheck Reversals with NYSDCP Refunds

If an agency submits a Request for Paycheck Reversal (AC-230) where the employee was on workers' compensation leave and had a deferred compensation

contribution refund, OSC's AC-230 Unit will remove the deferred compensation contribution from the AC-230 to prevent double processing. If the employee was not entitled to the deferred compensation refund, the agency must set up an overpayment for the amount of the deferred compensation refund.

Questions Questions regarding NYSDCP refunds may be directed to the Payroll Retirement mailbox.

Questions regarding processing AC-230s for checks that include a NYSDCP refund may be directed to the Payroll Deduction mailbox.

New York State Correctional Officers
& Police Benevolent Association, Inc.
102 Hackett Boulevard, Albany, NY 12209
(518) 427-1551 www.nyscopba.org nyscopba@nyscopba.org

RETIREE INFORMATION:

Workers' Compensation - Restoration of Accruals

Here is what to do if you believe that you are owed time from a workers' compensation case:

- Obtain or find a copy of your C8 or SROI form from the State Insurance Fund covering the dates in question.
- Send the C8 or SROI form to your facility with a brief cover letter explaining the situation and requesting the time be restored.
- If there is no response, send the letter again, requesting a written response. Mail the letter "return receipt requested".
- If the matter is still not resolved, file a grievance at the facility, requesting the time be restored. At the same time, send copies of all documents to NYSCOPBA, Attention: Dana Betts.
- After a few days, call Dana at NYSCOPBA (518-427-1551 x247) to review the paperwork.

ATTACHMENT 26 (1 page)

14.9 Workers' Compensation Leave

The Medical Evaluation Program (MEP) for workers' compensation will be continued. Employees opting into the MEP will receive the benefits provided herein. Those employees opting not to participate in the MEP will be eligible to apply for the statutory workers' compensation benefits. A light duty component shall be part of the MEP.

(a) An employee necessarily absent from duty because of occupational injury or disease as defined in the Workers' Compensation Law who is allowed leave from his position for the period of his absence necessitated by such injury or disease shall be: (1) first granted compensation leave with pay without charge to leave credits not exceeding cumulatively six months; and (2) upon exhausting leave pay benefits under (1) above be allowed to draw accrued leave credits; and (3) upon exhausting leave with full pay benefits under (1) and (2) above be allowed sick leave at half pay for which he may be eligible during such leave unless: (i) there is good and sufficient reason to believe that the disability resulting from such injury or disease is not job related or is primarily due to some pre-existing medical condition; (ii) there is good and sufficient reason to believe that the employee could report for work on a full-time or part-time basis; (iii) the employee's services would have been terminated or would have ceased under law; or (iv) the employee's claim for benefit is controverted by the State Insurance Fund.

(b) An employee allowed leave with pay under paragraph 14.9(a) may elect to draw accrued leave credits for part or all of his absence from duty before being granted leave with pay under paragraph 14.9(a)(1) above.

(c) If it is subsequently determined that an employee was not entitled to compensation leave with pay without charge to leave credits for any period for which he was granted such leave as provided herein above, he shall be required to make reimbursement for such paid leave from current or subsequent accumulations of leave credits at a rate and in a manner determined by the appointing authority.

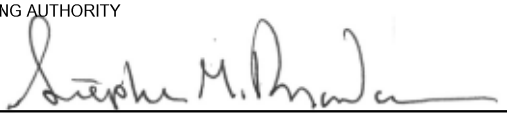
(d) An employee who draws leave credits as provided in paragraph 14.9(a) shall be entitled to restoration of such credits, including those used for absences of less than a full day, as are used during a period of absence for which an award of compensation has been made and credited to the State as reimbursement of wages paid. An employee who is necessarily absent from duty as described herein above may be granted compensation leave with pay without charge against leave credits for absences of less than a full day where such employee returns to work on a part-time basis.

(e) The Employer agrees that an employee eligible for Workers' Compensation Leave because of occupational injury or disease as defined in the Workers' Compensation Law, when absent from work for the purpose of attending a hearing scheduled by the Workers' Compensation Board in connection with such injury or disease shall be granted compensation leave with pay without charge to leave credits for such absence provided, however, that the cumulative total of compensation leave with pay not charged to leave credits granted for attendance at Workers' Compensation Board hearings or for absences necessitated by the occupational injury or disease shall not exceed six months.

(f) On the employee's prior written request at least three days in advance, the Employer will reschedule midnight or afternoon shift employees to attend a workers' compensation hearing to the normal day shift for the day of the hearing.

(g) An employee necessarily absent from duty and removed from the payroll because of occupational injury or disease as defined in the Workers' Compensation Law shall be treated as though on payroll for the period of disability not to exceed twelve months per injury for the purposes of coverage under the New York State Health Insurance Plan.

(h) The State and NYSCOPBA agree to continue the standing Joint Committee on Workers' Compensation. The Committee shall consist of an equal number of representatives selected by NYSCOPBA and an equal number of representatives selected by the State. The Committee will be responsible for the ongoing review and oversight of the MEP.

NEW YORK STATE Corrections and Community Supervision **DIRECTIVE**	TITLE **Workers' Compensation Benefits (Security Services)**		NO. 2208A DATE 05/07/2019
SUPERSEDES DIR #2208A Dtd. 08/04/16	DISTRIBUTION A	PAGES PAGE 1 OF 17	DATE LAST REVISED
REFERENCES (Include but are not limited to) ACA Expected Practices 4-4041, 2-CO-1B-11, 4-APPFS-3D-27, 4-JCF-6B-02; Directive #2218, #4065	APPROVING AUTHORITY 		

I. SCOPE: This directive outlines the conditions that must be satisfied and the procedure that is to be followed whenever an employee in the Security Services Unit or the Security Supervisors Unit requests Workers' Compensation benefits.

II. AUTHORITY

- Workers' Compensation Law
- Section 21.8 of the Civil Service Attendance Rules
- Section 71 of the Civil Service Law
- Rule 5.9 of the Rules for Classified Service
- Article 14.9 of the Security Services Unit and the Security Supervisors Unit contracts
- The Family and Medical Leave Act of 1993

III. CRITERIA: To receive Workers' Compensation benefits at full pay, the following criteria must be met:

- The employee must have Attendance Rule Coverage.
- The injury or illness sustained must be work related.
- The injury, illness or subsequent complications, must result in the employee being necessarily absent from his or her position.

NOTE: All Workers' Compensation claims accepted by the State Insurance Fund will be equitably administered regardless of an employee's race, color, religion, national origin, age, sex, disability, military status, or marital status.

IV. INFORMATION

A. Benefit Program: The following benefits may be granted to an employee necessarily absent from duty resulting from a non-controverted, work-related injury or illness:

1. Leave with full pay without charge to leave credits up to six months or a cumulative total of 182.5 calendar days.
2. Use of leave accruals: To participate in the Leave Benefit Program as provided in the negotiated agreements between New York State and the Security Supervisors Unit, and New York State and the Security Services Unit, employees injured on or after April 15, 1993 must complete the "Workers' Compensation Benefit Election Form," Attachment E, agreeing to be part of the medical evaluation process designed to return individuals to work on limited or light duty prior to full recovery.

B. Due Process: On December 6, 1989, the Rules for Classified Service were amended to add Rule 5.9 which provides due process in connection with Section 71 of the Civil Service Law. Reference is made to the NYS Dept. of Civil Service State Personnel Management Manual; Policy Bulletin #90-02, Section 2200, Separations and Leaves; and the NYS Dept. of Civil Service Attendance and Leave Manual, Policy Bulletin #90-02, Section 21.8.

1. Initial Notice Requirement: No later than the 21st workday of leave granted due to an accepted work-related injury or illness, the Superintendent of a correctional facility (Director of Personnel for Central Office employees) must provide the employee with written notice of the terms and conditions of his or her leave (see Attachment A). A copy of this letter is to be forwarded to Central Office Personnel.
2. Notice of Pending Termination: An employee who has been cumulatively absent for one year (two cumulative years of absence if work-related illness or injury resulted from an assault sustained in the course of his/her employment) must be provided with written notice of his or her proposed termination not less than 30 days nor more than 60 days prior to the proposed termination date. Upon a request for termination from a facility, the Director of Personnel will issue this notice. When an employee has been cumulatively absent for approximately 10 months and medicals give no indication of possible return to duty, the facility is to contact their Central Office Personnel representative. (Reference Section IV-I below).
3. Return from Leave: An employee who, after receiving a notice of a proposed termination, requests to return to duty, may be examined by the Employee Health Service prior to his or her return.
4. Denial of Return to Duty: An employee who has been found unfit to return to duty shall be informed in writing by the Director of Personnel of the reason for the denial and appeal rights. Civil Service Employee Health Services will provide the employee with a copy of the medical report and any other records on which the decision is based.
5. Appeal: Should the employee fail to appeal, the termination will be processed when the time limit for appeal has expired. Should the employee appeal, pursuant to Rule 5.9 of the Rules for Classified Service, the leave will be continued and a Hearing Officer appointed by the Department will conduct a hearing. The employee may be represented by an attorney or a union official. The appointing authority shall issue a finding of facts and a determination based on records assembled by the hearing officer. The employee may be returned to duty, continued on Workers' Compensation leave, or terminated on a finding of permanent disability. Appointing authority determinations are final, subject only to judicial review under Article 78 of CPLR.

C. Workers' Compensation Board Award: The Workers' Compensation Board has the power to hear and determine the eligibility of an employee for compensation benefits under the provisions of the Workers' Compensation Law.
Although the State Insurance Fund (SIF), as the State's insurance carrier, must comply with a Board decision, the Department is not bound by the Board decision when it can be clearly demonstrated that the employee was not disabled or the disability results primarily from a pre-existing medical condition (Article 14.9 of the Security Services Unit contract and Article 14.9 of the Security Supervisors Unit contract). See Sections IV-G and IV-L.

An award by the Board may include:

1. Credit to New York State for periods during which the employee was allowed leave with full pay without charge to credits.
2. Credit to New York State for periods during which an employee was absent using his or her own accruals after paid Workers' Compensation leave was exhausted and for which credits will be restored.
3. Payments made directly to the claimant for periods when the employee was on leave without pay (this may include claimants who exhausted accruals and half-pay eligibility or claimants whose cases were controverted by the Department).
4. Payments made directly to claimants when the SIF has been notified by the Department that contractual Workers' Compensation benefits are being denied by DOCCS under Article 14.9 of the Security Supervisors Unit contract and Article 14.9 of the Security Services Unit contract.

D. Administrative Reporting

1. Facility assignments: When an employee is injured at a correctional facility, the reporting procedure outlined in Directive #4065, "Reporting Injuries and Occupational Illnesses," is to be followed. Employees must immediately report to their supervisor any injury incurred on the job and proceed to the facility Medical Unit for assessment and treatment or stabilization as appropriate and to complete Form #1203, "Employee Accident/Injury Report," Attachment D. If the employee has been incapacitated, the supervisor must ensure that the injured employee is transported to the facility Medical Unit for assessment and treatment as appropriate. In the case of a life-threatening emergency, on the advice of the attending health professional, the injured employee may be transported for emergency care to an outside hospital without being taken to the Medical Unit. The supervisor must also complete the employee portion of Form #1203 "Employee Accident/Injury Report."

   However, if the Medical Unit is not staffed, the supervisor and the Watch Commander must assist in making arrangements for first aid or emergency medical services, as needed. In this instance, an "Employee Accident/Injury Report" can be obtained from the Watch Commander.

   The DSA must review and initial the Accident/Injury Report before the Personnel Office submits the Workers' Compensation claim form (C-2), via the New York State Civil Service Automated Reporting System (ARS).

2. Security staff assigned to the Training Academies or Central Office who are on facility payrolls: When an employee is injured on duty, the supervisor must assist in making arrangements for first aid or emergency medical services as needed, an investigation must be made, a Form #1203, "Employee Accident/Injury Report," Attachment D, is to be prepared, witnesses statements obtained, and a Workers' Compensation claim form (C-2), prepared with the appropriate facility name and address. All this information is to be forwarded to the facility from which the employee is paid for processing.

   Thereafter, the employee, if disabled as a result of the accident, is to provide medical statements, as described in Section E of this Directive, to the payroll facility concerning his or her continued disability and anticipated return to duty.

3. Correction Officer Trainees on Central Office Payroll: When a Correction Officer Trainee is injured while at the Training Academy, the supervisor must assist in making arrangements for first aid or emergency medical services as needed, a Form #1203, "Employee Accident/Injury Report," Attachment D, is to be prepared, an investigation conducted, reports from witnesses obtained, and a claim form (C-2), prepared. All documents are to be forwarded to Central Office Personnel for review and processing. The employee is to submit all medical statements concerning disability and anticipated return to duty to Central Office Security Personnel.

   This process must also be followed during the three weeks of OJT subsequent to the Correction Officer Trainee receiving a permanent facility assignment.

E. Medical Documentation: Initial medical documentation must be submitted within the first week of absence or upon return to duty, whichever occurs first. Thereafter, medical documentation must be provided every 30 days. For extended absences, approval may be granted to submit documentation every 45 days. An extended absence is defined as any period of absence in excess of 30 days from the submission of the initial medical documentation required within the first week of absence.

   In situations where the employee does not provide documentation **as outlined above**, or provides non-conforming documentation, a letter will be sent to the employees with instructions to provide conforming documentation by close of business seven days from the date the letter is mailed.

   Failure to provide conforming documentation by the date will result in the employee being placed in the appropriate status (AWOL or FMLA LWOP, if appropriate). If conforming documentation is received the employee will be returned to the appropriate leave status from the date the conforming documentation is received. Documentation must contain:

   1. Employee's Name,
   2. Date of Examination,
   3. Date of accident and dates of incapacitation,
   4. Statement of causal relationship,
   5. Diagnosis (International Classification of Diseases or ICD Codes are not acceptable),
   6. Prognosis,
   7. Estimated return to work date or date of next doctor's appointment, if applicable, and
   8. Signature and address of the medical practitioner.

   NOTE: Employees are encouraged to use the appropriate documentation form "Documentation for Workers' Compensation Leave," Attachment F of this Directive. An alternate form may be used for documentation, but all of the required information must be included.

   For conforming documentation requirements for Workers' Compensation doctor appointments, therapy, and tests, see Section F-8 of this Directives.

F. Requesting and Granting Leave

1. Once facility executive staff has made a determination regarding an employee's request for contractual Workers' Compensation benefits, the case information will be added to the KHRS Workers' Compensation Tracking System. The facility will forward all appropriate paperwork to the Central Office Personnel.
2. Whenever management has reason to believe an employee may be eligible for a limited duty assignment based on the nature of the injury or medical information received, an Independent Medical Evaluation must be requested through the State Insurance Fund. The employee's condition must be monitored on an ongoing basis, continued disability must be documented, subsequent requests for State Insurance Fund Independent Medical Evaluations must be pursued at least every three months, and frequent communication with the State Insurance Fund is encouraged.
3. If it is documented that an employee continues to be disabled from work, he or she can remain on paid occupational disability leave up to a maximum, continuous period of six months or a cumulative total of 182.5 days for each individual injury or disease. However, the employee will be required to provide conforming medical documentation of his or her condition as stated in Section IV-E of this directive.
4. If an Independent Medical Evaluation or the medical documentation from the employee's personal physician indicates that the employee is no longer disabled due to their Workers' Compensation injury, the employee must be ordered to return to full duty for their next scheduled shift. However, if the employee remains unable to return to full duty due to a personal medical condition, leave accruals may be charged, in accordance with Attendance & Leave guidelines.
5. Employees selecting the New York State Workers' Compensation Law Coverage on the election form and employees who refuse to work either full or limited duty assignments as the result of a Dispute Resolution decision, will be placed in the appropriate leave without pay status as described in section IV-L of this Directive. They may remain eligible to receive benefits under the NYS Workers' Compensation Law.
6. In those instances where the employee is absent from duty beyond the six month period provided by the contractual benefit, the employee will be required to exhaust other leave credits to cover the period of absence prior to requesting sick leave at half pay. Only when leave credits are exhausted and if the leave utilized totals less than one year, is sick leave at half pay to be granted. Reference is made to Directive #2206, "Sick Leave at Half Pay."
7. No female Correction Officer may be removed by DOCCS from Workers' Compensation benefits due to pregnancy or the birth of a child, nor must a female Correction Officer be scheduled for an Independent Medical Evaluation solely based on her pregnancy or the delivery of a child.
8. Granting of prior approved Workers' Compensation leave (Doctor's appointments, medical tests, physical therapy, etc.):
    a. To be considered pre-approved, a time off slip (Form #1031) must be filled out, and approved, no later than the previous day.
    b. Conforming documentation shall consist of an original note signed by the treatment Provider or designee that contains the date of accident, location, start time, and end time of the appointment.

c. Appointments of four hours or less:

(1) All Security Service Unit employees are required to provide conforming medical documentation from the treatment provider for all prior approved medical absences of four hours or less, upon their return to duty.

(2) Conforming documentation will not be subject to review to determine if the length of the absence was warranted, based on the location of the appointment and the start and end time of the appointment, so long as the total time of the absence was four hours or less.

d. Appointments of more than four hours:

(1) All Security Services Unit and Security Supervisors Unit represented employees are required to provide conforming documentation from the treatment provider for all prior approved medical absences of more than four hours, upon their return to duty.

(2) Conforming documentation will be reviewed to determine if the length of the absence was warranted, based on the location of the appointment and the start and end time of the appointment. Prior to approving more than four hours for a medical appointment, the Attendance Control Officer must closely question the need (i.e., location, time of the appointment, can it be scheduled during off hours, etc.).

e. Failure to submit required documentation will result in the employee being placed in **AWOL status (or FMLA LWOP, if appropriate)**.

f. Upon the second instance of fail to provide conforming medical documentation, employees shall be subject to discipline.

g. All notes and cards are subject to verification.

NOTE: Employees are encouraged to use the form, "Documentation for Prior Approved Workers' Compensation Leave," Attachment G. An alternate form may be used for documentation, but all of the required information must be included.

G. Restoration of Leave Credits: Credits and sick leave with half pay eligibility used to satisfy absences resulting from work-related injury or illness may be restored following a favorable decision by the Workers' Compensation Board that includes a credit to New York State for wages paid by DOCCS. Restored credits may not be used again in conjunction with the same compensation case. Leave credits used as noted in Section IV-C-4, will not be restored.

H. Termination Under Section 71 of the Civil Service Law: Section 71 of the Civil Service Law states the allowable periods of cumulative time that an employee may be absent for a work-related illness or injury before being terminated. An employee may be terminated for one cumulative year of absence due to a work-related illness or injury. However, an employee cannot be terminated until two cumulative years of absence due to a work-related illness or injury resulting from an assault sustained in the course of his/her employment.

When based upon supplied medical documentation, it appears that an employee may never return to full duty, the employee must be advised to contact the New York State and Local Employee Retirement System, regarding eligibility benefits under Disability Retirement programs.

In those instances where a supervisor recommends that an employee be granted a continuation of disability leave beyond one year or two years as described above, the request must be justified and approved by the Director of Human Resources.

I. Recurrences: Recurrences are defined as absences related to a Workers' Compensation illness or injury after the return to duty from the original absence. Each recurrence must be accompanied by conforming medical documentation as defined in Section IV-E, of this directive and entered into the KHRS Workers' Compensation tracking system. Recurrences are subject to requests for an Independent Medical Exam.

J. Return to Work: Security Services Unit employee are required to give notice of their intended return to duty eight hours prior to the beginning of the scheduled shift to which they intend to return. Both Security Service Unit and Security Supervisors Unit employees must submit conforming medical documentation directly to the facility Medical Information Officer before they will be permitted to return to duty. This documentation will be reviewed and the employee must receive prior approval to return to duty. Failure to provide notice may result in AWOL status (or FMLA LWOP, if appropriate), or disciplinary action.

When an employee returns to full or limited duty following recovery from a work-related illness or injury, the case must be updated on the KHRS Workers' Compensation tracking system and on the Civil Service Accident Reporting System.

K. Controverted Claim/Denial of Benefits

1. Definition: A controverted claim for Workers' Compensation Benefits occurs when the SIF challenges or disputes either the employee's claim of a work-related disability or the extent of the disability. The Department may separately deny benefits as outlined in Article 14.9 of the Security Supervisors Unit contract and Article 14.9 of the Security Services Unit contract. If there is good and sufficient reason to believe that the disability resulting from such injury or disease is not job related or is primarily due to some pre-existing medical condition, there is a good and sufficient reason to believe that the employee could report for duty, the employee's claim has been controverted by the State Insurance Fund, or the employee's services would be terminated or would have ceased under law.
2. Responsibilities: If a claim is being denied, the Personnel Office must update the Accident Reporting System that the employer is disputing the claim. All questionable claims are to be discussed with the Central Office Personnel representative. Following Central Office's decision to deny benefits, a detailed statement is to be filed with the SIF, notifying them, as our insurance carrier, of our recommendation to controvert the employee's claim with the Workers' Compensation Board. Attachments B and C are letters to be used to inform the State Insurance Fund and the employee that a claim is being denied.

L. When the SIF has determined that the employee is able to return to either full or limited duty, via an Independent Medical Exam and the employee supplies medical documentation that prohibits the employee from the ordered duty, the employee's Physician may file with the Dispute Resolution Program for a review of the conflicting medical opinions, as outlined in the Dispute Resolution Program Memo (MOU).

1. If the employee does not return to work in accordance with the independent Medical Examination determination and does not file a request for Dispute Resolution, but continues to supply medical documentation, the employee will be placed on leave without pay (LWOP) and will no longer be eligible for the contractual Workers' Compensation benefit.
2. If the employee does not return to work in accordance with an Independent Medical Examination determination, does not file a request for Dispute Resolution, and fails to supply conforming medical documentation, they will be placed on unauthorized leave without pay (AWOL) and will no longer be eligible for contractual Worker's Compensation benefit.
3. If based on a Dispute Resolution Program determination, the employee is ordered to return to duty and refuses to comply with the order, but continues to supply medical determination; they will be placed on leave without pay (LWOP) and will no longer be eligible for the contractual Workers' Compensation benefit.
4. If based on a Dispute Resolution Program determination, the employee is ordered to return to duty and refuses to comply with the order and fails to continue supply medical documentation, the employee will be placed on unauthorized leave without pay (AWOL) and will no longer be eligible for contractual Workers' Compensation benefit.
5. Any future benefit that the Workers' Compensation Board determines an employee is entitled to will be the statutory benefit with direct payment from the SIF if that employee refused to return to work as specified in the four scenarios above.

M. When an employee fails to document his/her claim for a work-related illness or injury or is ordered to return to duty as the result of an Employee Health Service exam and fails to return, he or she will be removed from payroll, placed on unauthorized leave and may be subject to discipline. In these instances, the facility's Central Office Personnel representative is to be notified and no charge to leave credit is to be allowed. The facility's Central Office Personnel representative will recommend whether the case should be referred to the Bureau of Labor Relations for review and appropriate action. The Personnel Clerk is to notify SIF of any change in an employee's payroll status.

N. Penalties: In accordance with Section 114 of the New York State Workers' Compensation Law, knowingly making a false statement or representation relative to a Workers' Compensation Claim is a class E felony. Any employee found to have made such a false statement or representation will be subject to immediate administrative action, including discipline and/or criminal prosecution.

If an employee who is absent due to a Workers' Compensation injury is placed on disciplinary suspension, the employee will be removed from the contractual Workers' Compensation benefit until he/she is removed from disciplinary suspension. Likewise, an employee cannot be placed on the contractual Workers' Compensation benefit due to a recurrence of a pre-existing injury during a period of disciplinary suspension.

O. Secondary Employment: A preexisting authorization for outside employment will be automatically reviewed for any period of time that an employee is on a limited-duty assignment or absent from work as a result of a work-related illness or injury (see Directive #2218, "Outside Employment").

PLEASE USE FACILITY LETTERHEAD

DATE

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Name
Address City, State Zip

Re: Workers' Compensation Leave
Effective _____

Dear Mr/Ms. _____:

You have been placed on Workers' Compensation Leave effective the date noted above. Pursuant to Section 5.9 of the Civil Service Rules for the Classified Service, please be advised that you have the right to a leave of absence from your position during your disability for one year or less if you are found to be permanently disabled. For specific information regarding Workers' Compensation Benefits, please refer to the employee contract for your bargaining unit.

You also have the right to apply for return to duty at any time during this leave. In the event that you are scheduled for a medical exam by the Employee Health Service to verify your fitness to return to duty and it is determined that you will not be allowed to return to duty, you have a right to a hearing to contest such a finding.

Should you not return prior to the expiration of your Workers' Compensation Leave, your employment will be terminated as a matter of law. You have a right thereafter to apply to the Civil Service Department within one year of the end of your disability for reinstatement to your position if vacant, to a similar position, or to a preferred list pursuant to Section 71 of the Civil Service Law and Section 5.9 of the Rules for the Classified Service.

As required by the Americans with Disabilities Act (ADA), it is the policy of this agency to make a reasonable accommodation to the known physical or mental limitations of an otherwise qualified individual with a disability. If you are an individual with a disability, as defined by the ADA, you may be entitled to an accommodation to enable you to perform the essential duties of your position. If you believe you would be able to perform the duties of your position with a reasonable accommodation, please contact this office for an application for requesting such an accommodation or for further information concerning the ADA.

Any injury/illness involving incapacity of more than three calendar days will result in those absences being designated Family & Medical Leave Act of 1993 (FMLA) leave, if you are eligible for such leave.

During your Workers' Compensation Leave, you are required to provide your supervisor with conforming medical documentation including diagnosis and prognosis every 30 days, unless you are advised otherwise.

Penalties. In accordance with Section 114 of the New York State Workers' Compensation Law, knowingly making a false statement or representation relative to a workers' compensation claim is a class E felony. Any employee found to have made such a false statement or representation will be subject to immediate administrative action, including discipline and/or criminal prosecution.

Secondary Employment. A preexisting authorization for outside employment will be automatically reviewed for any period of time that an employee is on a Limited Duty assignment or absent from work as a result of a work-related illness or injury (see Directive #2218, "Outside Employment").

Sincerely,

_____
Name

_____
Title

CC: Facility Personal History File

SAMPLE

_____

Senior Compensation Examiner
State Insurance Fund

_____

_____

Re: Name:_____
SSN: _____
Date of Accident: _____

Dear _____:

Please refer to the attached C-2 for _____.

We are denying this Workers' Compensation Claim for the following reason:

___ There is good and sufficient reason to believe the disability resulting from such injury or disease is not job-related or is primarily due to some pre-existing medical condition.

___ There is good and sufficient reason to believe that the employee could report for work on a full-time basis.

(Supporting justification must be stated. You must provide the fund with information and any documents you may have to support the controversion.)

encl:

cc: Central Office Personnel

SAMPLE

Date:

Employee Name
Employee Address

Re: Workers' Comp. Claim

Date of Accident:

Dear :

Your claim for Workers' Compensation Leave under Section 14.9 of the State/_____ agreement due to an alleged injury on _____ is denied.

___ There is good and sufficient reason to believe the disability resulting from such injury or disease is not work-related or is primarily due to some pre-existing medical condition.

Per Departmental regulations, you must submit medical documentation to _____. Medical documentation must be submitted within the first week of absence, and every two weeks thereafter.

Upon your return to work, please submit a doctor's note which must state that you were disabled from work and are now able to return to full duty, to _____. This note must be reviewed upon receipt for acceptability before you can return to work.

___ There is good and sufficient reason to believe that you could report for work on a full-time basis.

___ Your absence is considered as unauthorized. Contact the facility immediately.

___ Your claim for benefits is controverted by the State Insurance Fund.

You are also advised that should the Workers' Compensation Board make an award in your favor, any accruals used for absences related to this claim will not necessarily be restored.

If you have any questions, please contact me.

Sincerely,

Deputy Superintendent for Administration

cc: Central Office Personnel
Facility Personal History File

FORM 1203 (02/15) STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

EMPLOYEE ACCIDENT / INJURY REPORT

DELIVER THIS REPORT TO PERSONNEL WITHIN 24 HOURS
(#1 - 14 to be completed by Employee)

Personnel use Only (check one) ☐ Lost Time ☐ No Lost Time

1. Facility		2. Date of Accident
3. Time of Accident	4. Place of Accident	
5. Employee Name		6. Title
7. Employee Work Location	8. Shift	9. Pass Days
10. Employee remained on duty? Yes ☐ No ☐		11. Employee required medical attention? Yes ☐ No ☐

12. Statement of Employee

Note: Secondary Employment: A preexisting authorization for outside employment will be automatically reviewed for any period of time that an employee is on a Limited Duty assignment or absent from work as a result of an illness or injury (see Directive #2218, "Outside Employment").

13. Signature of Employee: _____ 14. Date: _____

15. Name of Eyewitnesses: _____

16. Statement of Supervisor: _____

17. Supervisor's Name	18. Supervisor's Signature	19. Date

FACILITY HEALTH SERVICES REPORT

20. Evaluation/Findings: _____

21. Services Provided: ☐ First Aid/Assessment ☐ Medical Treatment: _____

22. Personal Physician of Injured Employee: _____ Phone No.: _____

Address: _____

23. Date Injury Reported to Medical Unit: _____ 24. Time: _____

25. Signature: _____ 26. Title: _____

Distribution: White – Personnel Canary – Fire/Safety Officer Pink – Employee

WORKERS' COMPENSATION BENEFIT ELECTION FORM

New York State Council 82, NYSCOPBA or PBA of NYS Negotiated Agreements

To be completed by employee

INSTRUCTIONS: Please complete this form and submit it to your agency each time you file an accident report.

☐ Agency Police Services Unit

☐ Security Services Unit

☐ Security Supervisors Unit

Name	Social Security Number X X X – X X – _ _ _ _
Street Address	Home Telephone Number
City or Post Office State Zip Code	Date of Accident

I elect the following benefit program for all absences related to this accident:

1. **New York State Workers' Compensation Law Coverage only** ☐ Yes ☐ No
   I understand that if I elect the Law coverage only I will be placed on leave without pay for all absences related to this accident and I will receive only the benefits provided by the New York State Workers' Compensation law.

2. **Workers' Compensation Leave Benefit Program** ☐ Yes ☐ No

   I understand that if I elect the Leave Benefit Program, in addition to Law coverage, I will be eligible for the benefits as provided in the Council 82, NYSCOPBA or PBA of NYS negotiated agreements which include up to 6 months of paid leave, and use of credits and sick leave at half pay, if eligible. I also understand that to receive these benefits I must participate in the medical evaluation and limited duty components of this Program.

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information which you are being asked to provide on this form is being requested pursuant to Article 14 of the Council 82, NYSCOPBA or PBA of NYS negotiated agreements for the principal purpose of determining whether you quality for employer-provided workers' compensation benefits and will be maintained by the Personnel Office in the agency or facility in which you are employed. Failure to provide this information may result in delay of processing benefits. This information will be used in accordance with Section 96 (1) of the personal Privacy Protection Law particularly subdivisions (b), (d), and (e). For further information relating only to the personal Privacy protection Law, contact your personnel Office.

Signature	Date

DOCUMENTATION FOR WORKERS' COMPENSATION LEAVE

- Medical documentation must be submitted to the facility Medical Information Officer, not facility medical staff.
- Initial medical documentation for Workers' Compensation must be submitted to the facility Medical Information Officer within the first week of absence or upon return to duty, whichever occurs first.
- For Workers' Compensation absences, documentation is to be submitted to the facility Medical Information Officer on an ongoing basis, normally every 30 days but not less than once every 45 days for extended absences.
- Conforming medical documentation must be submitted to the facility Medical Information Officer UPON RETURN TO DUTY, unless otherwise ordered to return to full or limited duty because of an Independent Medical Evaluation.

Employee's Name: _____

Date of Injury: _____

Date of First Treatment for this Injury: _____

Date of Examination: _____

Date Employee is Incapacitated From: _____ To: _____

Prognosis:

_____

Diagnosis: (Required for all Workers' Compensation absences, regardless of length)

_____
(International Classification of Diseases or ICD Codes are not acceptable)

Re-Evaluation Date: _____ and/or Full Duty Date: _____

☐ This Injury/Illness is Work – Related (Workers' Compensation)

_____
Signature of Medical Provider or Designee

Date Signed: _____

Location of Office Where Examination Took Place:

_____
_____
_____

An alternate form may be used for documentation but all of the required information must be included. All documentation is subject to verification.

WC (02/18)

DOCUMENTATION FOR
WORKERS' COMPENSATION LEAVE
PRIOR APPROVED APPOINTMENTS

Conforming medical documentation must be submitted to the facility Medical Information Officer **UPON RETURN TO DUTY**.

Employee's Name: _____

Date of Injury: _____

For Workers' Compensation Medical Provider Appointments this box must be completed.
Start Time of Apt: _____ End Time of Apt: _____

_____
Signature of Medical Provider or Designee

Date Signed: _____

Location of Office Where Examination Took Place:

_____

_____

_____

An alternate form may be used for documentation but all of the required information must be included. All documentation is subject to verification.

SEC WC APT (03/17)

Reporting Procedures for Security Employees

A. Employee's Responsibilities:

1. Report their injuries immediately or as soon as possible to the area supervisor to ensure proper medical treatment/relief (employees only also are expected to report injury to the NYS Accident Reporting System at 1-888-800-0029 within 24 hours of the accident/injury absent any extenuating circumstances);
2. Report to facility health care unit for examination by medical staff;
3. Cooperate in the investigation of any accident;
4. Complete items 1 - 15 of an "Employee Accident/Injury Report" (Form 1203), and submit it to medical staff for completion of the health services report section; and
5. Complete a "Benefit Election Form" (Attachment E) and submit it along with the original Form 1203 to the facility personnel office (employee can complete the social security number section by entering "on file").

B. Supervisor's Responsibilities:

1. Call the Health Services Unit for necessary medical assistance;
2. Ascertain and report facts and circumstances of accidents and injuries occurring within their areas, and record this information on the "Employee Accident/Injury Report" (Form 1203) they will be expected to provide data to the facility's Unusual Incident System (UIS) reporter);
3. Complete the supervisor's segment of the "Employee Accident/Injury Report" (items 16 - 19, Form 1203) and assist employees who have been incapacitated by their injury to complete the employee segment of that report; and
4. Notify the fire/safety officer of any serious accidental injuries and any injuries which indicate unsafe conditions, and assist the fire/safety officer in completing an "Accident/Injury Investigation Report" (Form 1599) in a timely manner.

C. Medical Unit:

1. Promptly respond to the medical needs of any person injured within the facility, consistent with prudent medical judgment; and
2. Complete the "Facility Health Services Report" segment of the "Employee Accident/Injury Report" (Form 1203) at the time of initial treatment and give it to the injured employee (or the area supervisor, if the employee is incapacitated) for further completion and submission to the facility personnel office.
3. Provide the injured employee with a copy of Attachment F – "Documentation for Workers' Compensation Leave."

D. Personnel Responsibilities:

1. Receive and review the "Employee Accident/Injury Report" (Form 1203) and "Benefit Election Form" (forwarding copy of the #1203 form to the Fire and Safety Officer for follow-up investigation);
2. Complete an "Employer's Report of Injury/Illness" (Form C-2) with the Worker's Compensation Board within 10 days after the occurrence of a reportable injury on the Accident Reporting System (ARS) and update claim information as appropriate;
3. Ensure that Form C-11 is processed on the ARS to notify the State Insurance Fund and the Workers' Compensation Board that there has been a status change of an employee who has been absent due
to a compensable workers' compensation incident, including notice that the employee has returned to work or to report intermittent lost time;

4. Maintain the NYS Dept. of Labor "Log of Work Related Injuries and Illnesses" (Form SH-900) and enter each recordable case on the log within six working days after learning of its occurrence;
5. Post the annual summary of work related injuries and illnesses for the previous year, using Form SH-900.1 as required by 12 NYCRR 901.32; and
6. Request consultant medical examinations through the State Insurance Fund as appropriate.
7. Provide the employee with a Claimant Information Packet.

E. Deputy Superintendent for Administrative Services' Responsibilities:

1. Ensure that Workers' Compensation claims are filed and processed accurately and take corrective action when warranted;
2. Review questionable cases and ensure that witnesses' statements are submitted;
3. Review any preexisting authorization for outside employment in accordance with section IV-N of this directive and section III-E of Directive #2218, “Outside Employment.”
4. Monitor the Workers' Compensation Benefit Program on an ongoing basis; and
5. Discuss questionable cases with the State Insurance Fund and the Central Office Personnel representative.

F. Timekeeper's Responsibilities:

1. Post absences, re-credit and restore accruals as directed by the Personnel Office (status change);
2. Identify absences with date of accident and carrier case number, with intermittent lost time, it is imperative that the time records reflect the date of accident to which it is related; and
3. Report any problems, inconsistencies or discrepancies to the Personnel Office.

G. Fire/Safety Officer's Responsibility:

1. Thoroughly investigate any case of serious accidental injury to any person within the facility, or any other "recordable" injury as defined in section II-E of Directive #4065, “Reporting Injuries and Occupational Illnesses”, and complete an "Accident/Injury Investigation Report" (Form 1599) with the employee's supervisor; and
2. Establish and maintain annual logs (Forms 1592 and 1592.1) to provide running records of employee/volunteer, visitor, contractor, and inmate accidents.

H. Payroll's Responsibilities:

1. Process appropriate PAYSR transaction to correspond to the NYSTEP transaction submitted by the Personnel Office and in accordance with the Office of the State Comptroller bulletins; and
2. Notify Personnel Office of any conversations with the Office of the State Comptroller which may impact on employee's pay status or claim.

I. State Insurance Fund:

1. Record facility calls on lost time accidents and issue carrier case number;
2. Investigate claims; contest claims where there is evidence that no disability exists or where there is a question that the disability may not be causally related to the reported accident;
3. Schedule consultant examinations when appropriate;
4. Appeal an initial determination of the Workers' Compensation Board where there is substantial evidence to support the original decision to controvert the claim; and
5. Comply with final determination of Workers' Compensation Board.