**CITY OF MARCO ISLAND**

**AT-TIME-OF-INJURY PACKET**

**Each At-Time-of-Injury Packet contains the following:**

1. Employee’s Work Injury Instructions/Accident Reporting Procedures
2. Employee Post-Accident Process Checklist - ***Completed by Safety Officer / Supervisor***
3. First Report of Injury – ***Completed by Safety Officer / Supervisor***
4. Employee Incident Report – ***Completed by Employee***
5. Statement by Witness Form– ***Completed by Witness***
6. Accident Investigation Report - ***Completed by Safety Officer / Supervisor***
7. Employee Acknowledgement Form & Florida Workers’ Compensation Fraud Statement
8. Attending Physician’s Return to Work Recommendations and Light Duty Form

**ALL CLAIMS SHOULD BE EMAILED BY HR TO:**

[wcclaims@pgcs-tpa.com](mailto:wcclaims@pgcs-tpa.com)

**City of Marco Island**

Worker’s Compensation

EMPLOYEE’S WORK INJURY INSTRUCTIONS

1. Notify your Supervisor/Manager Immediately.
2. Seek first aid treatment/medical treatment, if needed.
3. Medical treatment can be obtained at Advanced Medical – Naples or Marco Island Urgent Care during normal working hours, after hours use Physician’s Regional Hospital located on CR 951.
4. Complete and Sign *Employee Incident Report* which includes the *Employee Medical Release Statement.* Complete all documentation in its entirety before leaving (unless unable).
5. Give your completed *Employee Incident Report* to your Supervisor/Manager immediately.
6. Notify your supervisor to arrange transportation to the preferred provider.
7. Please have your physician send all service bills and medical records to:

**Preferred Governmental Claim Services (PGCS)  
Post Office Box 958456   
Lake Mary, FL 32795   
Tele:  800-237-6617  
Fax:   321-832-1448**

**Send all workers comp billing to - Billing Address:**

**Amerisys**

P.O. Box 614004

Orlando, FL 32861

1. Notify your Supervisor/Manager of your status within 24 hours.
2. Return ***Medical Treatment Form and Light Duty Form*** to your Safety Officer or designated official within 24 hours of being released from medical facility and keep a copy for yourself as medical instructions are listed by your physician.
3. All documentation should be submitted to Human Resources, as soon as possible, for entry into the Workers Compensation Claims System.

**Accident Reporting Procedures**

Safety Officer provides HR with First Report of Injury and Accident Investigation Form

Injury

Medical Treatment Non-Emergency

Employee Escorted to Doctor

Call

911

First Aid Only

Human Resources notified

239-389-3970

IMMEDIATELY

Clinic communicates with Human Resources

Doctor Treats Employee and Doctor Determines Restrictions

Safety Officer or designated official notifies Human Resources and submits First Report of Injury and Accident Investigation Report.

Notify Safety Officer

IMMEDIATELY

Treat and Return to Work –

Complete “First Report of Injury” form and “Accident Investigation” Form and send to

Safety Officer

Emergency

Employee returns to work following Doctor’s instructions.

An employee who sustains a job-related injury will be entitled to Workers’ Compensation (W/C) leave in accordance with federal and state laws and City policy.

* **Prior authorization for medical treatment under workers’ compensation is required.**
* Employees have an obligation to cooperate in seeking timely treatment for job related injuries, furnishing information related to the injury, providing documentation related to any medical treatment, and any internal or external investigation.

**Reminder: Employee with serious or life-threatening injuries should be transported to the nearest medical facility. Contact 911 for emergency medical assistance and transportation, if necessary.**

|  |  |
| --- | --- |
| **Primary Medical Treatment:** | **Advanced Medical Center** |
|  | 720 Goodlette Frank Road, Suite 500 |
|  | Naples FL 34102 |
|  | 239-566-7676 |
|  | Hours: Monday – Friday 8:00am – 8:00 pm  Saturday and Sunday 9:00am – 5:00pm |
| **City Contact:** | Leslie Sanford, Human Resources Manager  239-389-3970  [lsanford@cityofmarcoisland.com](mailto:lsanford@cityofmarcoisland.com) |
| **Claims Adjuster / Administrator:**  (Medical treatment management; authorizations; claim processing; bill payment) | Preferred Governmental Claim Services (PGCS) Post Office Box 958456  Lake Mary, FL 32795  Tele:  800-237-6617 (24/7/365) Fax:   321-832-1448 |
| **Primary Contact:** | Cheryl Riley, Director of Claims  PGCS Claim Services  800-237-6617 x 4054  or Direct 321-832-1444  [criley@pgcs-tpa.com](mailto:criley@pgcs-tpa.com) |
| **Lost Time adjuster:** | Edgardo Hernandez  PGCS - WC Specialist II  (P) 321-832-1439  (F) 321-397-5407  Email [eddie.hernandez@pgcs-tpa.com](mailto:eddie.hernandez@pgcs-tpa.com) |
| **Medical Only Adjuster** | Martha Turner  (P):  800-237-6617 x 4036  (F):   321-832-1448  [martha.turner@pgcs-tpa.com](mailto:martha.turner@pgcs-tpa.com) |

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**City of Marco Island**

**EMPLOYEE POST-ACCIDENT PROCESS CHECKLIST**

*Immediate actions for medical triage and accident investigation to be completed by Safety Officer or designated official and WC Designee in the event of employee injury.*

Attend to the employee and his/her injuries – Where it is practical and does not expose anyone to risk of harm, administer first aid and allow the employee time to recover and then evaluate the need for outside medical attention. If the injury is minor and does not require immediate outside medical attention, utilize rehabilitative duty for the remainder of the shift. If an employee passes out or is exposed to a blood borne pathogen (needle stick, laceration from a contaminated surface, or body fluids) all forms must be filled out and given to the HR Department regardless of the employee not wanting medical attention at the time of incident.

If outside medical attention is required:

* + Refer the employee to the appropriate medical provider.
  + Provide the employee with the ***Light Duty Form*** to be completed by the treating physician.
  + If a chemical exposure has occurred, provide the physician with the chemical’s ***Material Safety Data Sheet.***

Visit the scene and conduct a reenactment of the accident – Conduct the reenactment at the scene of the accident whenever possible, and as soon after the accident takes place as possible, on the same shift, unless the employee’s injury keeps him/her from doing so. **Immediately address and eliminate any hazard found (i.e., water on floor – clean up immediately and place a wet floor sign near the area.)**

Employee and Witness Interviews are CRITICAL – Probe for the real cause(s) of the accident. Don’t just stop at one or two questions. Each level of questioning will get you closer to the root cause that contributed to the injury.

Required Reports are to be completed – A list of required reports includes:

* + ***Report of Injury*** - To be completed by the Safety Officer or designated official.
  + ***Employee Incident Report*** – To be completed by the employee immediately. Do not complete it for the employee unless unusual circumstances dictate. Have the employee sign the Employee Medical Release Statement at the bottom of the incident report. The employee has the right to refuse to sign but determining why the employee has a concern is important. Educate the employee that signing will allow for faster processing of an injury claim. If issues still exist, discuss with the workers’ compensation department.
  + ***Statement by Witness*** – Secure all witness statements by having the witness complete this form. Make sure all statements are signed and dated. If there are no witnesses, complete the form and mark “None”.
  + ***Accident Investigation Report*** – To be completed by the Safety Officer or designated official. Be sure to provide a specific description of the injury, and events leading to the injury, including people, equipment and other variables. Also take pictures of the accident/incident sight and surrounding area from as many angles as possible.

Take corrective action – After the investigation is complete and the primary and secondary causes of the injury have been identified, remove or eliminate the causes to reduce the risk of the same injury occurring again.

**City of Marco Island**

**First Report of Injury or Illness**

*FLORIDA DEPARTMENT OF FINANCIAL SERVICES*

*DIVISION OF WORKERS COMPENSATION*

*(NOI –NOTICE OF INJURY)*

*Please click on the graphic below to enter information directly into the FORM and SAVE the form for your use.*

*OR*

*Print out the First Report of Injury and complete the information manually.*

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**City of Marco Island**

**INCIDENT REPORT**

REPORT TO BE COMPLETED BY THE **EMPLOYEE**

(Submit Completed Form to Safety Officer or Designated Official)

*Report to be completed during the shift incident occurred.*

EMPLOYEE INFORMATION

1. Employee ID:
2. Name (*First, middle, last)*:
3. Job Title:
4. Department Name:
5. Supervisor Notified:
6. Date Reported:                 Time Reported:                 AM PM
7. Name of Witness(es), if any – State none, if none:

STATEMENT

1. Date of Injury or Illness:                          Time of event:                AM PM
2. Explain in detail what happened, how it happened and where incident occurred. (Be specific.) (Please attach additional sheet/s if necessary)

1. Describe affected body parts. (What body part/s and how affected.)

1. Have you ever had a similar injury to the affected body part? □Yes □No If yes, please explain and provide treating physician’s name:

1. Does employee want outside medical attention? Yes No (If no, should the need arise at a later date, notify your supervisor immediately.) If yes, what is the physician’s name:
2. Is Supervisor or designated official requiring medical assistance for the employee? Yes No

Employee Signature Date

Employee Medical Release Statement:

BY SIGNING THIS AUTHORIZATION, I WAIVE PHYSICIAN/PATIENT CONFIDENTIALITY AND ANY OTHER PRIVILEGE OF CONFIDENTIALITY AND, BY SUCH WAIVER, AUTHORIZE MY TREATING PHYSICIAN, OTHER PHYSICIAN, HOSPITAL, REHABILITATION PROVIDER OR OTHER HEALTH CARE OR HEALTH CARE SERVICES PROVIDER OR INSURANCE CARRIER OR CLAIMS REPRESENTATIVE (UPON PRESENTATION OF THIS AUTHORIZATION OR ANY PHOTOSTATIC COPY OF THIS AUTHROIZATION TO (1) TALK TO MY EMPLOYER, CITY OF MARCO ISLAND AND ITS RELATED ENTITIES, OR ANY REPRESENTATIVE OF CITY OF MARCO ISLAND WITHOUT MY BEING PRESENT, CONCERNING ANY INJURY, ILLNESS, DISEASE, DIAGNOSIS, TREATMENT, IMPAIRMENT, DISABILITY, WORK LIMITATIONS, CAUSE OR LENGTH OF DISABILITY SUSTAINED OR SUFFERED BY ME OR AFFECTING, INVOLVING OR PERTAINING TO ME, AND MY RECOVERY AND RETRUN TO WORK; AND (2) RELEASE TO CITY OF MARCO ISLAND OR ANY REPRESENTATIVE OF CITY OF MARCO ISALND ANY NON-GENETIC HEALTH INFORMATIO SUCH AS, MEDICAL OR HOSPITAL RECORDS, DIAGNOSTIC FILMS AND FINDINGS, REHABILITATION RECORDS, PSYCHIATRIC AND PSYCHOLOGICAL TREATMENT RECORDS AND ANY OTHER WRITTEN INFORMATION REGARDING ME. THIS AUTHROIZATION INCLUDES THE AUTHORITY TO COPY ANY RECORDS, PAPERS, ETC.

Employee Signature Date

Case #:

**City of Marco Island**

**STATEMENT BY WITNESS**

(Submit Completed Form to Safety Officer or Designated Official)

*Report to be completed during the shift incident occurred.*

WITNESS INFORMATION

1. Employee ID:
2. Name (*First, middle, last)*:
3. Job Title:
4. Department Name:
5. Supervisor Name:
6. Contact number:

STATEMENT

1. This Incident Pertains to Whom:
2. Date of Injury or Illness:                                    Time of event: AM PM
3. Explain in detail what happened, how it happened and where incident occurred, be specific. (Attach additional sheets as necessary)

**I HEREBY CERTIFY THAT THE INFORMATION AND DESCRIPTION COMPLETED BY ME ABOVE IS AN ACCURATE AND TRUE REPRESENTATION OF WHAT I WITNESSED.**

Employee Signature Date

**City of Marco Island**

**ACCIDENT INVESTIGATION REPORT**

REPORT TO BE COMPLETED BY THE SAFETY OFFICER OR DESIGNATED OFFICIAL WITHIN 48-HOURS.

(Submit Completed Form to Human Resources IMMEDIATELY)

EMPLOYEE INFORMATION

1. Name (*First, middle, last)*:
2. Title:
3. Department Name:
4. Supervisor Name:

INFORMATION ABOUT THE PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL

1. Was first aid administered by Employer? Yes No
2. Was outside medical attention obtained? Yes No *If Yes, please answer the following:*
3. Name of Hospital or Urgent Care facility:
4. Street:                                    City:                          State:      Phone#:
5. Was the employee in the emergency room?: Yes No
6. Was the employee hospitalized overnight as an inpatient?: Yes No

INFORMATION ABOUT THE CASE

1. Date of Injury or Illness:                 Time of event:      AM PM
2. Date Reported:                 Time Reported:           AM PM
3. Time employee began work:                AM      PM
4. Location of Accident:
5. Please describe what happened to the employee to cause the incident? Describe the activity as well as the tools, equipment or material the employee was using. Be specific.

                              

1. What was the injury or illness? What part of the body was affected and how was it affected? (Be more specific than “hurt”, “pain”, or “sore”. *Examples: “strained back”, “swollen ankle”, “carpal tunnel syndrome.”*

1. What object or substance directly harmed the employee? *Examples: “wet floor”, “chemical burn, hand” (If this question does not apply to the incident, please use “N/A”.)*

1. What corrective action was taken? (Use additional sheet as necessary)

1. Was accident preventable?

1. If employee died, when did death occur? Date of Death:
2. Date &Time Investigation Completed: Date                         Time:                      AM PM

Report Completed By:                                         Title:

Phone:                          Date

***Signature of Person Completing this Report:***

A picture containing text, clipart

Description automatically generated

**INJURED EMPLOYEE ACKNOWLEDGEMENT OF RECEIPT, READING AND**

**UNDERSTANDING OF THE FLORIDA WORKERS’ COMPENSATION LAW**

Effective October 1, 2003, Florida law requires anyone seeking payment for benefits, goods, or services as provided for by Florida’s Workers’ compensation statues must attest, he or she has received, read, and understand, the following statement:

**Any person who, knowingly and intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Section §817.234 Florida statues.**

Please acknowledge you have received, read and understand the statement in bold above by printing and signing your name in the space provided.

If you fail to or refuse to sign this form, any benefits to which you may be entitled may be suspended until such time as you sign & return this form to Human Resources/Risk Management Division.

By signing and dating below, I acknowledge I have received, read, and understand the fraud statement in bold typeface above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

(Sign your name on the line above) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name on the line above) (Provide your social security number on the line above)

  
**City of Marco Island**

**WORKERS COMPENSATION  
LIGHT DUTY POLICY INFORMATION FORM**

The City of Marco Island is hereby informing the attending physician of our light or restricted duty policy for all injured employees seeking medical attention. **Our employees are our most valuable resource, and our goal is to provide them with the best care so that we can bring them back to work as soon as possible.** We would like to request the treating physician to consider our light duty option so the employee can return to work the following day.

We are willing to assign the employee with alternative duties outside of their normal scope of work (i.e., clerical, administrative, answering phones. filing. etc.) Transportation to and from work can also be provided for the injured employee, if necessary. Please list tasks that the employee is capable of performing in order to consider light duty.

Light duty, if available, will only be on a temporary basis and offered at the discretion of the City.

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Our insurance carrier is: PGCS – Preferred Governmental Claim Services – 1-800-237-6617

Please Contact: Leslie Sanford, 239-389-3970 for any questions.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Employee’s Name Employee ID# Physician’s Name

(Please Print) (Please Print)

Employee’s Signature Physician’s Signature