CITY OF DUNN WORKERS' COMPENSATION PROCEDURES

Pursuant to North Carolina General Statute 97-1 all employers with three or more employees are required to obtain insurance to cover all job related injuries and/or occupational diseases.

The purpose of the workers' compensation act is to cover employees who suffer an injury by accident or an occupational disease. All injuries must arise out of and in the course and scope of the covered employment to be considered.

PROCEDURES

1. **A Form 19 "Employers Report of Employee's Injury or Occupational Disease to the Industrial Commission" form should be completed by a supervisor and faxed to Key Risk Management (336-605-7502) within 24 hours. Forward a copy to the Administration office for filing purposes.**

2. **The supervisor should complete the employer section of the City of Dunn Physician's Report/Pharmacy Guide form and have the injured employee take this form with them to an authorized treating physician. Please have the physician complete the middle section and return this form to the supervisor. Forward a copy to Administration.**

3. **If referral to a specialist is necessary, authorization from the Key Risk adjuster is needed.**

4. **If a prescription is required, the employee will need to take the Physician's Report/Pharmacy Guide with them to a participating Tmesys pharmacist. Communicate this vendor name, to the pharmacist and the prescription will be filled with no "out-of-pocket" cost to the injured employee. The Tmesys Pharmacy Network will bill Key Risk on a direct basis.**

5. **Provide the employee with a copy of the completed Form 19 along with a copy of a blank Form 18. Under the provisions of the Workers' Compensation Act, the employer is required to provide the employee with a Form 18 "Notice of Accident to Employer and Claim of Employee Representative, or Dependent".**

6. **Supervisors should complete the Supervisor Statement and forward a copy to Administration for filing purposes.**

7. **If non-emergency medical treatment is required, ALL employees are to go to the following medical facility:**

   1. **Med Fast Urgent Care**
      605 W. Cumberland Street
      Dunn, NC 28334
      (910) 891-1391
      Hours: M-T-W-Fri. 9:00 a.m.-5:30 p.m.
      Th. 9:00 a.m. – 2:00 p.m.
      Sat. 9:00 a.m. - 2:00 p.m.
      Sun. 1:00 p.m. – 4:00 p.m.

In the event that Med Fast is closed, please send the employee to one of the following participating providers:

Manuel Lopez, MD – 700 Tilghman Dr. – 892-4941
John Mann, MD – 700 Tilghman Dr. – 892-7175
Eastern Carolina Medical Center – 1 Medical Dr. – Benson – 894-5787
Coats Medical Clinic – 25 N. Johnson St. – Coats – 897-6423

During normal business hours, you may call a Key Risk Claim Professional at 866-847-8872.

****After hours, holiday and emergency situations, use the Key Risk Claims Department Emergency number at 888-883-9568. Please use this number for catastrophic injuries only.**

****For all emergencies and life threatening injuries, employees should go directly to the nearest emergency room facility.**

North Carolina Industrial Commission

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

IC File #________

*Emp. Code #________

*Carrier Code #________

Employer FEIN________

Carrier File #________

*Required Information.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name:
Address:
City / State / Zip:
Home Telephone: ( ) -
Work Telephone: ( ) -
Social Security Number: - -
Sex: ☐ M ☐ F
Date of Birth: / /

Employer's Name: CITY OF DUNN — Telephone Number: (910) 230-3500
Employer's Address: P.O. BOX 1065 — City: DUNN — State: NC — Zip: 28335
Insurance Carrier: Key Risk Management — Policy Number: 161
Carrier's Address: PO Box 49129 — City: Greensboro — State: NC — Zip: 27419
Carrier's Telephone Number: (866) 847-8872
Fax Number: (336) 605-7502

Section	No.	Item
Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred — County — Department — State if employer's premises
	3.	Date of injury / / — 4. Day of week — Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day — 6. Date disability began / / ☐ A.M. ☐ P.M.
	7.	Date you or the supervisor first knew of injury / / — 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Time employed by you — (b) Wages per hour $
	11.	(a) No. hours worked per day — (b) Wages per day $ — (c) No. of days worked per week
		(d) Avg. weekly wages w/ overtime $ — (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. — 15. If so, at what wages $ per
	16.	At what occupation — 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died — 20. If so, give date of death (Submit Form 29) / /

Employer name ________ Date Completed / /
Signed by ________ Official Title ________

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No	Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

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FOR IC USE ONLY
RESEARCHER: ____
CC: ____
EC: ____
DATA ENTRY: ____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

**SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/**

Supervisor Statement

☐ *witnessed the accident* ☐ *did not witness the accident*

Was employee wearing appropriate safety equipment?

Was employee following City of Dunn Safety policy?

Description of the accident...

SIGNATURE: ______________________ DATE: ______________

Physician's Report / Pharmacy Guide

KeyRisk

Expertise is no accident

MAILING ADDRESS: P.O. Box 49129, Greensboro, NC 27419
(866) 847-8872 www.keyrisk.com

EMPLOYER: Please complete the top section and give to the injured employee to take with them to their authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee/Patient: **Last:**	**First:**
Date of Injury:	
Name of Employer / Company:	
Employer Signature:	Name of Doctor chosen:

EMPLOYEE: Please take this form with you to an authorized treating physician. Please have the physician complete the middle section and return this immediately to your employer. The bottom section is for you to show the pharmacist should you need to have any prescriptions filled as prescribed by your authorized treating physician for this work related injury.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: ____

A post accident drug test (check one) ( ) **has** been completed ( ) **has not** been completed

In accordance with this patient's physical capability, check all that apply:

- ( ) May resume work immediately, no restriction.
- ( ) May resume work immediately with the following restrictions:
  - ( ) Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
  - ( ) Light work (lifting less than 20 pounds)
  - ( ) Medium work (lifting less than 50 pounds)
  - ( ) Heavy work (lifting less than 100 pounds)
  - ( ) Normal shift
  - ( ) Limited hours: ____ 2 hrs, ____ 4hrs, ____ 6hrs per day
  - ( ) Other: ____

- ( ) Repetitive Motion Restrictions (specific to hand/arm injuries):

Frequency	Left	Right
No Use		
Occasional <33% of time		
Frequent 34-66% of time		
Regular 67-100% of time		

- ( ) Patient may return to work at full duty on (date) ____________________
- ( ) Patient has a return appointment on (date) ____________________ at (time) ____________

Please indicate any referrals that are required: ____

Physician's Signature	**Date**	**Physician's Name (type or print)**

Be sure to contact Key Risk's Claim Department at 1-866-847-8872 for authorization for the referral.

PHARMACIST: Process all prescriptions on-line through ***Tmesys*** for this patient. See your pharmacy manual for ***Tmesys*** Payor or Index information. Contact the ***Tmesys*** Help Desk at 800-964-2531 to establish eligibility prior to processing on-line. **DO NOT CHARGE THE PATIENT FOR THE PRESCRIPTION.**

CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME
Bi-Lo Pharmacy	input code: TMS	Horizon Pharmacy	TYS	Revco drugs	TMWC	VIX Pharmacy	carrier code: TME
Bi-Mart	index: TMESYS	HyVee Drugtown	index: bin # in 3rd party set up	Rite-Aid drugs	TMESYS	Walgreen's	carrier code: TMEWC
Brooks Drugs	Code: TME	J & J Pharmacy	TCS	RX Discount Pharmacy	input code: ME	Wal-Mart phcy	carrier: TME
Brookshire Brothers	Condor Code: 2050	Joel & Jerry's	index: TME	Sack-n-Save	plan#: 6012 or 5097	Wegman Pharmacy	carrier code: TME
Cub Pharmacy	Carrier Code: TYS	Kash N Karry	plan: TYS	Sav-A-Lot	60	Winn-Dixie	Index: TME (plan 2066)
CVS Drugs	Condor Code: 8822	Kerr Drugs	TMESYS	Sams Club Pharmacy	carrier code: TME		
Drug Emporium	TYS	K-mart phcy	Carrier code: TYS	Save Mart	Carrier code: TYS		
Eckerds(all others)	Termimal plan:2801	Long's Phcy	plan: #1,TMES	Stop N Shop	146		
Franck's Pharmacy	price code: TM	Medicine Shoppe	varies by each store system	Super D	Plan name:332		
Fred Meyer	TYS	Medistat Phcy	Condor code: 2425	Super Valu	carrier code: TYS		
Fred's Pharmacy	TMESYS	Milner-Rushing Drugs	compensation as Tom Ashley	Super X (HSI)	index: TME		
Giant Pharmacy	TMESYS	Pathmark Pharmacy	TYS	Tom Thumb Phcy	pdx code: TMS		
Goodings	TME index D, bill code TME	Perry Drg Str	index:TS	Tops Pharmacy	access code: TI		
Hannaford Food & Drug	index: TYS	Phar-Mor	TYS	Tri Daly Drugs	Carrier code: TMS		

tmesys

*ALL PARTICIPATING PHARMACIES HAVE NOT BEEN INCLUDED ON THIS LIST. PLEASE HAVE YOUR PHARMACY CALL TMESYS REGARDING ANY QUESTIONS/AUTHORIZATIONS (800) 964-2531.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

Emp. Code #__________

Carrier Code #__________

Employer FEIN__________

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name

Address

City State Zip

( ) - Home Telephone ( ) - Work Telephone

\- - Social Security Number ☐ M ☐ F Sex / / Date of Birth

Employer's Name ( ) - Telephone Number

Employer's Address City State Zip

Insurance Carrier Policy Number

Carrier's Address City State Zip

( ) - Carrier's Telephone Number ( ) - Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: ________ (Time of Injury) on / / (Date (required)) at ________ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) ________

Describe how the injury or occupational disease occurred: ________

Occupation when injured: ________ Nature of employer's business: ________

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $________ Number of hours worked per day: ________ Days worked per week: ________

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent

( ) - Telephone Number

Address City State Zip / / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

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8/1/08
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FOR IC USE ONLY
RESEARCHER: ____
CC: ____
EC: ____
DATA ENTRY: ____

FORM 18

MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/