

**COUNTY OF ORANGE, VIRGINIA
PERSONNEL POLICIES MANUAL**

WORKERS' COMPENSATION

POLICY NO.: 4.15

EFFECTIVE DATE: 10/1/96

REVISED: 11/1/06

OVERVIEW: In compliance with the Virginia Workers' Compensation Act, the County is committed to ensuring all employees incurring a work related injury or disease will receive worker's compensation benefits.

SCOPE: This policy applies to all County employees regardless of employment status.

PROVISIONS:

A. Benefits:

At no cost to employees, the County provides workers' compensation insurance that covers injuries or occupational illnesses as described below:

A covered injury is one which occurs at work or a work-related function, is caused by a specific work activity, and which happens suddenly at a specific time. Injuries incurred gradually or from repetitive trauma are not covered.

A covered occupational illness is a disease caused by the work which is not a disease of the back, neck, or spinal column. An ordinary disease of the life is not an occupational illness.

The County provides all of the benefits provisions identified by the Virginia Workers' Compensation Act. Benefits typically include time-loss benefits after seven (7) calendar days for temporary or permanent partial disability, death benefits, paid medical expenses, and rehabilitation services.

B. Responsibilities:

The Human Resources Department will be responsible for the administration of the program.

Employees are responsible for reporting every work related injury or illness, regardless of their severity, to their immediate supervisor. If possible, the employee should complete a First Report of Accident (VWC Form 3) report at the time he/she informs the immediate supervisor.

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The immediate supervisor is responsible for notifying Human Resources upon learning about the incident/injury. The immediate supervisor will assist the employee with completion and review the First Report of Accident as necessary, and then forward it to Human Resources as soon as possible, but no later than 48 hours after of the incident is reported to the supervisor.

Human Resources is responsible for all necessary reporting to the County's insurance carrier, and will process forms necessary to ensure proper reporting and distribution of workers' compensation payments and for maintaining all required files/records and for posting the OSHA notices.

C. Medical Treatment:

If an injured employee requires medical attention, he/she shall be given a list of authorized physicians from which the employee may receive treatment. The employee must choose from this list. If an employee elects to use a physician who is not on the authorized list, his or her workers' compensation benefits could be jeopardized. It is the employee's responsibility to ensure that the physician understands that it is a workers' compensation claim and the bill should be submitted to Orange County Human Resources or the County's workers' compensation insurance company and not to the employee's health insurance carrier.

To ensure receipt of the maximum benefits pertaining to payment of medical expenses and workers' compensation payments, an employee must accept medical treatment and keep appointments with the authorized physician. The physician first treating the employee will become the authorized treating physician unless he/she refers the employee to another physician, who would then become the treating physician. Once a treating physician has been identified, the employee may not change physicians without prior approval of the County's workers' compensation insurance carrier.

If the injury causes the need for an employee to receive emergency treatment, the medical panel provision will be waived until the emergency is completed. Once the emergency is over, a medical panel will be offered and the employee would be required to choose a treating physician.

D. Compensation during Incapacity:

Following the first seven calendar days of incapacitation resulting from a work-related injury/illness, an eligible employee will receive a tax-exempt payment from the County's workers' compensation insurance carrier equal to two-thirds of his/her average weekly salary (including average overtime) or the maximum weekly salary established by the Virginia Workers' Compensation Commission (VWCC), whichever is less.

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An eligible full-time employee may elect to have the County continue providing his/her regular pay (not including overtime), and transfer his or her workers' compensation payment to the County. If this option is chosen, the employee must sign an agreement (Form 4.15.1) electing this option, requesting that all workers' compensation checks be mailed to the County of Orange Human Resources Department, and agreeing to endorse to the County all worker's compensation payments received that correspond to the monthly salary payment made by the County. This option is available for a period not to exceed 90 days.

E. Light Duty Assignment

The County will attempt to employ all persons unable to perform the full duties of their normal position in a "light duty" position, when they are released by their physician to return to work with limitations. In some cases, this position will be the same as they held when they were temporarily incapacitated, but with some tasks temporarily suspended. Where this is not possible or practical, at its discretion the County will attempt to find other temporary work that will return the employee to the workplace.

If an employee is returned to light duty, and the light duty assignment results in less pay than the average weekly salary that served as the basis for workers' compensation payments, the employee will continue to receive workers' compensation payments at a reduced level based on the difference between the average pre-injury pay and the amount received while working in the light duty assignment.

If the employee has chosen to receive full pay from the County in lieu of receiving workers' compensation benefits, he or she will continue to receive full pay from the County instead of light duty pay (if different) and will continue to endorse to the County any supplemental workers' compensation checks received.

F. Coordination with Family and Medical Leave

If an employee is eligible for workers' compensation benefits due to a serious health condition which prevents him/her from working (e.g. from performing one of more of the essential functions of his/her job), then he/she is also eligible for FMLA leave. As soon as the County is notified by the employee or his/her physician of the need to be absent from work due to a serious health condition that is expected to last two weeks or more, the Human Resources Department shall notify the employee, in writing, that the absence is being counted as FMLA leave. FMLA leave shall end when the employee returns to unrestricted work or when he/she returns to work in a light duty position. See County Policy 5.3, Family and Medical Leave.

Employer's Accident Report
(formerly: Employer's First Report of Accident)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form

The boxes to the right are for the use of the insurer	Reason for filing	VWC file number
	Insurer code or PEO Ref. No.	Insurer location
	Insurer claim number	

Employer		
1. Name of employer (trading as or doing business as, if applicable)	2. Federal Tax Identification Number	3. Employer's Case No. (if applicable)
4. Mailing address	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business (NAICS code, if applicable)	
8. Name and Address of Insurer or self-insurer for this claim	9. Policy number	10. Effective date

Time and Place of Accident				
11. City or county where accident occurred	12. Date of injury	13. Hour of injury <input type="text"/> a.m. <input type="text"/> p.m. 13a. Time began work <input type="text"/> a.m. <input type="text"/> p.m.	14. Date of incapacity	15. Hour of incapacity
16. Was employee paid in full for day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. Was employee paid in full for day incapacity began? <input type="checkbox"/> Yes <input type="checkbox"/> No		
18. Date injury or illness reported	19. Person to whom reported	20. Name of other witness	21. If fatal, give date of death	

Employee			
22. Name of employee (Last, First, Middle)	23. Phone number	24. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
25. Address	26. Date of birth	27. Marital status <input type="checkbox"/> Single <input type="checkbox"/> Divorced	
	28. Social security number	<input type="checkbox"/> Married <input type="checkbox"/> Widowed	
29. Occupation at time of injury or illness (SOC code, if applicable)	30. Is worker covered by PEO policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	31. Number of dependent children <input type="text"/>	
32. How long in current job?	33. Date of Hire	34. Was employee paid on a piece work or hourly basis? <input type="checkbox"/> Piece work <input type="checkbox"/> Hourly	
35. Hours worked per day <input type="text"/>	36. Days worked per week <input type="text"/>	37. Value of perquisites per week Food/meals Lodging Tips Other	
38. Wages per hour \$ <input type="text"/>	39. Earnings per week (inc. overtime) \$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>

Nature and Cause of Accident			
40. Machine, tool, or object causing injury or illness		41. Specify part of machine, etc.	
42. Describe fully how injury or illness occurred			
43. Describe nature of injury or illness, including parts of body affected			43a. Overnight inpatient hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No
			43b. Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No
44. Physician (name and address)		45. Hospital or Clinic (name and address)	
46. Probable length of disability	47. Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes	48. At what wage? 49. On what date?
50. EMPLOYER: prepared by (name, signature, title)		51. Date	52. Phone number
53. INSURER: (name of processor)		54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable)	57. Address	58. Phone number	

INSTRUCTIONS

Employer's Accident Report (formerly Employer's First Report of Accident) VWC Form No. 3

Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required on line 50 of the form.
2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.
3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.
4. If you need additional copies of this form, please request them from your insurance carrier, claims servicing agency, or third party administrator.

Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.
2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.
3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission. A PEO must use the VWCC reference number.
4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.
5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).
6. This form can be filed electronically. If you would like more information, please go to the Virginia Workers' Compensation Commission's Web site (www.vwc.state.va.us) or call us at (804) 367-2084.

*The criteria are (1) lost time exceeds seven days, (2) medical expenses exceed \$1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.

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**AGREEMENT TO RECEIVE COUNTY PAY
IN LIEU OF WORKERS' COMPENSATION**

This agreement is between _____, an employee of Orange County Government (the "employee") and Orange County Government, (the "County").

Whereas the employee is eligible to receive workers' compensation payments from the County's workers' compensation insurance company, and

Whereas the employee desires to continue to receive his/her regular compensation from the county in lieu of such workers' compensation payments, and

Whereas the County is agreeable to continue the employee's regular pay,

The employee hereby requests that all workers' compensation checks be mailed to the County of Orange Human Resource Dept. and agrees to endorse to the County all such workers' compensation payments that correspond to the monthly salary payment made by the County.

Signed this _____ day of _____

Employee Signature

Print name

Orange County Human Resources