	CITY OF NEWTON, MASSACHUSETTS PERSONNEL POLICY AND PROCEDURE	POLICY NO: 404:1 PAGE 1 OF 4 PAGES EFFECTIVE DATE: 10/3/83

SUBJECT: WORKERS' COMPENSATION

1. POLICY

The City provides Workers' Compensation coverage under the law. The program is un-insured and covers payment of applicable medical expenses which are the result of injury incurred at their regular place of work or when on authorized City business away from their regular place of work. It also provides for payment of compensation benefits as a result of a compensable job incurred disability.

2. SCOPE

This procedure covers all full-time and less than full-time employees of the City, excluding elected and appointed officials, teachers employed by the School Department, covered by the Newton Teacher's Association labor agreement and employees covered by the labor agreements with the Newton Branch of the Massachusetts Police Association and the Newton Firemen's Welfare Association.

3. RESPONSIBILITY

Employees are responsible to report immediately (unless incapacitated) all injuries incurred while working at their job to their immediate supervisor. If the immediate supervisor is not available at that time, the employee shall report the injury to any other supervisor available in his/her department.

Immediate Supervisor - Phone Workers' Compensation Agent immediately to report injury to one of your employees. All supervisors are responsible to insure that their employees are aware of and comply with this procedure. Supervisors shall not permit any employee, injured on the job, and absent more than three (3) days, to return to work without a specific written authorization from the City Physician. Supervisors are responsible for taking immediate steps to correct hazards and any other unsafe conditions which directly or indirectly caused injury to an employee. This action to be taken in conjunction with or as recommended by the Safety Officer.

Personnel Department - The Workers' Compensation Agent is responsible for the overall administration of this program including processing of all claims and maintenance of all records and forms pertaining to claims, (excluding privileged medical records which shall be maintained by the City Physician).

City Physician - The City Physician, or his designated appointee, shall be responsible for examing all employees injured on the job. Also, establish and maintain all medical records pertaining to each injured employee. The City Physician or his designated appointee shall maintain regular contact

with each injured employee until the employee returns to work or is declared totally and permanently disabled. Employees, injured on the job and absent more than three (3) days, shall not be allowed to return to their work without the written authorization of the City Physician or his designated appointee.

City Solicitor - Shall provide advice and counsel to the Workers' Compensation Agent on questions pertaining to the interpretation and application of the Workers' Compensation Act. This office shall also represent the City in all litigations and claim settlements and hearings before the Industrial Accident Board.

4. PROCEDURE

1. Employee - reports injury received on the job to his supervisor unless incapacitated.

2. Supervisor - phones Workers' Compensation Agent to report injury as soon as possible. 552-7039 or 552-7040.

3. The Supervisor shall give the injured employee the following forms:

A. "Employee Notice of Injury", form WC-1 (Exhibit 1). The injured employee completes this form and returns it to the Supervisor. Form must give specific details of injury e.g. at approximately 1:30 p.m. I lifted a fifty pound barrel of soap. The barrel was on the ground and I lifted it on to a shelf that was four feet high. I felt a sharp pain in my right shoulder as I put the barrel on the shelf. I went to Newton-Wellesley Hospital for medical treatment at 3:00 p.m. the same day. If safety equipment is provided state whether or not you were wearing same at the time of your accident. Upon review for clarity and completeness, the Supervisor shall immediatley send one copy to the Workers' Compensation Agent, one copy to the Safety Officer.

B. "Physician's or Surgeon's First Report", form SF-2 (Exhibit 2). Instruct employee to have this form completed by the attending physician at the time of injury. However, no claim under Workers' Compensation will be processed until this form is completed. This completed form is to be forwarded by the employee or the physician to the Workers' Compensation Agent as soon as possible.

5. Supervisor - Each time an employee is injured on the job the Supervisor shall immediately complete SF-1 (Standard Form For Employer's First Report Of Injury). Standard Forms for reporting accidents may be obtained from the Workers' Compensation Agent in the Personnel Department, City Hall. This form will be completed in quadruplicate. After form has been completed and signed by official for department all four copies should be sent to the Workers' Compensation Agent. Forms will be sent by Workers' Compensation Agent to the following:

   A. Original to the Industrial Accident Board

   B. Second copy for employee's injury file for compensation purposes.

   C. Third copy to City Physician. EXHIBIT 3

   D. Fourth copy will be returned to the department for employee's departmental file folder.

6. Upon receipt of Exhibits 1, 2 and 3 the Workers' Compenstion will complete a case file for the injured employee.

7. The Workers' Compensation Agent shall proceed to process claims for Workers' Compensation made by employees injured on the job. No person shall be placed on Workers' Compensation until all aspects of this procedure are satisfied and each claim is reviewed with the City Physician. The Workers' Compensation Agent will consult with the City Solicitor, as necessary, on questions pertaining to claims.

8. The City Physician, or appointed designee, shall examine all individuals injured on the job and establish and maintain a "Medical Profile of Injured Employee" form WC-3 (Exhibit 4). A copy of this form shall be forwarded to the Workers' Compensation Agent and an updated copy thereafter, each time any information is added to the form.

9. Each employee injured on the job, and absent more than three (3) days, shall not be permitted to return to work without a "Return to Work Authorization" form WC-4 (Exhibit 5) completed by the City Physician or his designated appointee. This form is given to the employee, who gives it to his/her supervisor. A copy of this form is forwarded to the Workers' Compensation Agent by the City Physician's office.

10. BUDGETING AND REQUESTS FOR APPROPRIATION

The Personnel Director will be responsible for budgeting and all requests for appropriation of funds needed for Workers' Compensation.

A. The Workers' Compensation Agent will prepare the weekly Workers' Compensation payroll. The Director of Personnel will sign the payroll and forward one copy to the Comptrollers Office, one copy to the Retirement Office and one copy will be retained in the Personnel Department.

The Workers' Compensation Agent will determine which employees are eligible for Workers' Compensation, based on evaluation of each claim including reports and information from Department Heads, City Physician, and as required, the Office of the City Solicitor.

B. Medical Bills will be approved for payment by the Department Head, City Physician, Workers' Compensation Agent and the Director of Personnel. Bills will be forwarded to the appropriate Department Head for signature. The Department Head should immediately return signed bills to the Workers' Compensation Agent who will then process bills for payment.

EMPLOYEE
NOTICE OF INJURY

Each time an employee is injured on the job this form is to be completed by the injured employee and given to the immediate Supervisor or Department Head. Form is to be completed as soon as possible after injury.

Employee Name:_____ Job Title:_____

Department Name:_____ Supervisor's Name:_____

Date of Injury:_____ Time of Injury:_____ A.M. P.M.

Describe Where Injury Happened:_____

_____

_____

_____

Describe Injury Received:_____

_____

_____

_____

_____

Describe How Injury Happened:_____

_____

_____

_____

_____

Name(s) of Witness to Your Injury:_____

_____

_____

_____

_____

_____ _____ _____

Employee Social Security Number | Employee Signature | Date

EXHIBIT 2 404:1

WORKMEN'S COMPENSATION PHYSICIAN'S or SURGEON'S FIRST REPORT

(For necessary filing date)

1. Employer .....

2. Employee: ..... (STREET) ..... (CITY) ..... (STATE) ..... Age ..... (Sex) .....

3. Date of Injury? ..... (STREET) ..... (CITY) ..... (STATE) ..... Date of your first treatment? .....

Was patient treated by anyone else? ..... By whom? ..... When? .....

Who engaged your services? .....

4. Employee's statement of cause of illness or injury: .....

(USE REVERSE SIDE IF NECESSARY)

5. Is there any history or evidence present of pre-existing injury or disease and if so, what? .....

6. Give an accurate and complete description of the nature and extent of the injury or disease including objective findings, subjective complaints and diagnosis.

(In the case of a disease, give occupational history and exposure warranting diagnosis with date of onset of symptoms and disability): .....

7. In your opinion was the accident or exposure as above described a producing or contributing cause of the injury or disease? .....

8. Hospitalized? ..... Date? ..... Where? .....

9. X-ray taken? ..... Number of x-rays taken? ..... By whom? .....

10. Date employee was or will be able to return to regular light work? .....

11. Explain nature and extent of permanent disability, including any scarring or other disfigurement (if none, so state. If death ensued, give date and cause): .....

12. Was employee discharged from treatment? ..... If so, when? .....

13. Remarks and description of treatment given by you .....

ADDITIONAL REPORT FOR EYE INJURIES

		Right eye	Left eye
O	Vision in each eye at examination R20/ L20/		
P	Mark position of foreign body, cuts or ulcers on diagram		
T	Was either eye previously injured? ..... If yes, to what extent and what scars or loss of vision previously existed		
I			

A I am a duly licensed physician in the state of .....

L Date of report ..... Signed .....

Office address ..... (STREET) ..... (CITY) ..... (STATE) ..... (TEL. NO.) PERSONAL SIGNATURE

If your treatment of this injury has ended, please submit in space below or on separate sheet, your fully itemized bill for our consideration.

IMPORTANT—Was other expense incurred for treatment of this injury? .....

EMPLOYER'S FIRST REPORT OF INJURY

Complete in triplicate. Mail the white original to → within 48 hours of the occurrence of injury or diagnosis of an occupational ss. Mail the second copy to the insurance company providing your rker's Compensation insurance. Retain the remaining copy for your rds.

The Commonwealth of Massachusetts
Division of Industrial Accidents
Leverett Saltonstall Building, Government Center
100 Cambridge Street, Boston 02202

TYPE OR PRINT A RESPONSE TO EACH APPLICABLE QUESTION OR ITEM. READ INSTRUCTIONS ON THE REVERSE SIDE BEFORE FILLING OUT FORM.

EMPLOYEE

1. First Name | Initial | Last | 2. Social Security Number

3. Home Address (no. & street, city, state, zipcode) | Home Telephone Number

4. Marital Status ☐Single ☐Married | 5. Sex ☐Male ☐Female | 6. Date of Birth (mo., day, yr.) | 7. If a juvenile, was an employment certificate or permit on file? ☐Yes ☐No

8a. Regular Occupation | 8b. Occupation When Injured (if different) | 8c. No. of days on non-regular job when injured: | 9. How Long In Your Employ?

EMPLOYER

10. Name

11. Office Address (no. & street, city, state, zipcode) | Telephone Number

12. Name of Insurance Company (not agent) Providing Your Worker's Compensation Insurance

13. Nature of Business or Article Manufactured

EMPLOYEE'S WAGE DATA

14a. Piece or hourly worker? | 14b. Wage per hr. $ | 15a. No. hrs. worked per day | 15b. Wage per day $ | 16a. Days Worked Per Week

16b. Ave. Weekly Earnings $ | 17. Where applicable, give number of meals furnished the employee each week, and estimated value per day, week or month of any lodging, fuel, etc. furnished employee:

OCCUPATIONAL INJURY OR ILLNESS DATA

18. Date and Time of Injury | 19. Was injured paid in full for this day? ☐Yes ☐No | 20. Date Disability Began | 21. Probable Length of Disab.

22. Nature of Injury or Illness (cut, bruise, sprain, burn, amputation, dermatitis, poisoning, etc.)

23a. If Injured Has Returned To Work – 23b. At What Wage? – 23c. At What Occupation? | 24. Address or Location Where Injury/Illness occurred

Date / / Hour m. | $

25. On Employer's Premises? Yes No | 26. Employee's Assigned Department | 27. Part(s) of Body Affected (eye, fingers, back, ankle, lungs, etc.)

28a. If Injured Has Died, Enter Date of Death / / | 29. To Whom and When Was Injury/Illness Reported?

30. Name and Address of Witnesses

31. Name and Address of Physician

32. Name and Address of Hospital

ACCIDENT INFORMATION

33. Describe fully how accident or exposure occurred, and state what the employee was doing when injured.

34. Specify the source - machine, tool, substance or object most closely associated with the accident or exposure

Type of Accident or Exposure (fall, struck by, fell against, overexertion, contact with toxic substance, etc.)

36. Kind of Power (hand, foot, electrical, etc.) | 37. Part of Machine on Which the Accident Occurred

38a. Was a relevant safety appliance or regulation provided? ☐Yes ☐No | 38b. Was it in use or in force at the time? ☐Yes ☐No

Signed By | Title | Date | Board No.

DO NOT WRITE IN THIS COLUMN

18. Date
24. Location
5. Sex
6. Age
9. Length of Service
13. Industry (S.I.C.)
8b. Occupation (S.C.C.)
22. Nature
27. Part of Body
34. Source
35. Type
33. Associated Object or Subject
16b. Weekly Wage
Coded by

1

C.R. 24482

Form approved by I.A.B. 7/82 White Paper

MEDICAL PROFILE OF INJURED EMPLOYEE

Employee Name_____ Job Title_____

Department_____ Supervisor's Name_____ Injury: Date_____ Time_____ AM-PM

Date of First Examination by City Physician_____

Description of injury and how it happened:

Is Employee able to immediately return to their regular job? Yes____ No____. If no, describe, including restrictions, prescribed treatment, and when (give date) Employee will be able to return to their regular job:

Initial Medical Treatment: Physicians Name_____ Address_____

Telephone Number_____ Date and Time of Initial Treatment_____, _____ AM PM

Comment:

Form WC-4. (Exhibit 5)

MEDICAL STATUS FORM

Date _____

Employee Name _____ Department _____

Supervisor's Name _____

1. ☐ * This Employee's absence is no longer justified by reason of sickness or injury, and he/she is medically capable to perform his/her job as described in his/her job description.

_____

2. ☐ At this point in time the employee is not Physically capable of the following:

He/she will be capable of all of the above on _____

3. ☐ Employee is to see me again on _____ at _____ AM. PM.

_____ Date

_____ Authorized Signature/City Physician's Department

* See Section 2-245 of Revised Ordinance 1979.