Employee Report of Assault*

(Compliant with Section 25 of the RTA Collective Bargaining Agreement, Protection of Teachers)

☐ **ASAR** ☐ **BENTE** ☐ **RAP** ☐ **RTA**

Employee Section
(Please type or print legibly)

To: _____ **Date** _____ **School** _____
(Principal)

From: _____

WORKERS COMPENSATION REPORTS MUST BE COMPLETED FOR ALL WORK RELATED INJURIES. A FULLY COMPLETED WC FORM COPY MUST BE ATTACHED TO THIS REPORT. (THE ORIGINAL SHOULD BE SENT TO EMPLOYEE BENEFITS.) THIS REPORT MUST BE FILED WITHIN 3 BUSINESS DAYS OF THE INCIDENT UNLESS EMPLOYEE IS MEDICALLY UNABLE TO COMPETE.

Incident: **Date** _____ **at** _____ **with** _____
(Time) **(Student's Name)**

_____ _____
Employee's signature **Union Representative/s Signature**

Principal Section
To: **Superintendent of Schools/His/Her Designee**

From: _____ **Date** _____
(Principal)

Check applicable action:
☐ **Long-Term Suspension Referral (copy required)**
☐ **In School Suspension/Alternative to Suspension (copy required)**
☐ **Other, please explain** _____
_____

_____
(Principal's Signature)

Enc. **Copy Workers Compensation Form**

cc: **Union Office**

***A separate Application for Assault Pay must be completed if loss of time occurs.**

(Rev. 5/2009)

RCSD EMPLOYEE INSTRUCTIONS FOR REPORTING OF OCCUPATIONAL INJURY OR ILLNESS

1) Employees shall report all work-related injuries immediately to their supervisor.

2) The injured employee must complete and sign the District's Workers' Compensation First Report of Injury and Illness Reporting Form, and forward a copy of the form to their supervisor within the first 24 hours of the injury.

3) The supervisor or administrator must sign the injury form and ensure the report is immediately reported to the District's Workers' Compensation third party administrator, POMCO, Inc. at "cstobnic@pomcogroup.com" **and** the District's Risk Management (HCI) "Workers.Comp@rcsdk12.org" Email folder **along with** any additional documents pertaining to the incident. Contact information for POMCO and the District is below.

4) Should the employee leave work in an emergency situation, the incident should be reported to the supervisor and the District Risk Mangement Department (HCI) IMMEDIATELY. The incident will still need to be electronically reported in order to generate a claim for the injured employee. ****Please do not delay reporting the incident, the signed document and materials can be subsequently submitted through email, fax or interoffice mail.*** ***

INFORMATION FOR THE INJURED WORKER:

1) An injured employee is entitled to obtain medical treatment relating to the injury or illness.

2) An injured employee should choose a physician or facility who accepts N.Y.S. Workers' Compensation Insurance.

3) Should the injured employee receive medical treatment after the initial incident report, the employee can contact POMCO at 1-877-236-7475, or the RCSD HCI-Risk Management Office at 262-8320 to provide information.
   a. Should the injured employee need medical treatment, the employee **must** inform the treating facility, the injury/illness is work related and to directly bill POMCO for related services.

4) An injured worker should not pay a deductible for receiving medical treatment. If an injured worker does pay for a medical service, including prescriptions or medical equipment, etc., they should seek to have the monies reimbursed from POMCO.

5) If the injured worker feels the injury or illness prevents him/her from working, he/she needs to notify his/her supevisor and if he/she remains out of work for **more than three (3) consective days**, medical documentation must be submitted to the District, (see collective barganing agreements). This documentation will need to be reviewed in the Benefits/Risk Management Departments.

CONTACT INFORMATION:

HCI-Risk Management
131 West Broad Street
Rochester, New York
585-262-8320 or 585-262-8578
585-295-2614 (fax)

POMCO, Inc.
P.O. Box 325
Syracuse, New York 13206
877-236-7475
315-433-5473 (fax)

Every child is a work of art. Create a masterpiece.

WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

Employee Signature _____ Date _____

SECTION IV: WITNESS(ES)

☐ Yes ☐ No

Name (please print) _____ Phone # _____

Name (please print) _____ Phone # _____

SECTION V: SUPERVISOR INFORMATION

Date Supervisor Notified: (Month/Day/Year)	Time Supervisor Notified: ☐ AM ☐ PM	

Principal/Supervisor Name (please print) _____

Principal/Supervisor Signature _____ Date _____

BY SIGNING THIS FORM, YOU ARE AFFIRMING THAT ALL INFORMATION PROVIDED BY YOU IS TRUE. PLEASE NOTE THAT KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH AN APPLICATION FOR WORKERS' COMPENSATION OR DISABILITY BENEFITS IS A CRIME. ANY PERSON KNOWINGLY MAKING A FALSE STATEMENT IN CONNECTION WITH THIS APPLICATION MAY BE SUBJECT TO CRIMINAL PROSECUTION THAT COULD RESULT IN FINES AND/OR IMPRISONMENT.

Every child is a work of art. Create a masterpiece.

WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

Answer ALL questions. Sign, and give to your supervisor immediately. Please make and retain a copy for your records.

Section I: EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Telephone Number	Date of Birth	Age	Gender ☐ M ☐ F	Social Security Number	Average Weekly Salary

Address	City	State	Zip Code

Occupation/Title	Date of Hire	Work Status ☐ full-time ☐ part-time	Hours/day	Hours/week	Department

School Building / Location Accident Occurred (Street, City, Zip Code)	Immediate Supervisor

Section II: EMPLOYEE MEDICAL INFORMATION

Medical Treatment Received? ☐ Y ☐ N ***(If no medical treatment, proceed to Section III)***

*****Should the injured employee receive medical treatment after the initial incident report, the employee can contact POMCO at 1-877-236-7475 or the RCSD Risk Management Office at 262-8320 to provide information.*****

Any Lost Time ☐ Y ☐ N	If yes, date disability began	If out of work: will salary be continued

Name of Attending Physician	Inpatient Hospitalization

Address of Attending Physician	Name of Hospital

City	State	Zip Code	City	State	Zip Code

Section III: INCIDENT INFORMATION *(Please complete the entire section)*

Date of Injury or Illness: (Month/Day/Year)	Time of Injury/ Illness	☐ AM ☐ PM

Is This a Recurrence of a Previous Injury or Illness

☐ Yes ☐ No

If "Yes" Please Give Details (i.e., date of previous injury and provide details)

Describe Part (s) of Body Injured/Nature of Occupational Illness (i.e., left arm, right foot, head, multiple, etc.)

Nature of Injury / Illness (i.e., laceration, burns, fracture, strain, etc.)

Cause of Injury / Illness (motor vehicle, machine, strain, or injury by lifting, etc.)

Injury/Occupational Illness Description

If Employee Unavailable for Signature, Explain Circumstances in this Space and Enter Incident

OVER →

Application for Assault Pay (AAP)

To Be Completed By Employee
(Please type or print legibly)

Date Submitted: _____

To: Meghan Abate, Director of Labor Relations
District Designated Representative

From: _____
Bargaining Unit Member

Location/School: _____ Date of Assault: _____

First date of lost time due to assault _____

Expected date of return to work _____

Date Employee Report of Assault and Workers Compensation forms were filed with

Principal/Immediate Supervisor _____

_____ _____
Employee's Signature Date

_____ _____
Union Representative's Signature Date

Required Attachments:
☐ Related Medical Documentation
☐ Medical Release

cc: Union Office

(Rev. 2/2012)