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 COMPLETE.

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

ce:  Union Office

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

(Rev. 2/2012)
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 catherine@pomcogroup.com and the District’s Risk Management (HCP) 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 Management Department (HCP) 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 HCP-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 supervisor and if he/she remains out of work for more than three (3) consecutive days, medical documentation must be submitted to the District, (see collective bargaining agreements). This documentation will need to be reviewed in the Benefits/Risk Management Departments.

CONTACT INFORMATION:

HCP-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)

Rochester City School District- 131 West Broad Street-Rochester, New York 14614
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**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
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<thead>
<tr>
<th>Telephone Number</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>Average Weekly Salary</th>
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<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tr>
<th>Occupation/Title</th>
<th>Date of Hire</th>
<th>Work Status</th>
<th>Hours/Day</th>
<th>Hours/Week</th>
<th>Department</th>
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<tr>
<th>School Building / Location Accident Occurred (Street, City, Zip Code)</th>
<th>Immediate Supervisor</th>
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**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   If yes, date disability began   If out of work: will salary be continued
[ ] Y   [ ] N

Name of Attending Physician

Inpatient Hospitalization

Address of Attending Physician

Name of Hospital

City | State | Zip Code
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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 ➔
WORKERS' COMPENSATION
FIRST REPORT OF INJURY AND ILLNESS

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
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SECTION IV: WITNESS(ES)

| Yes | No |

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<th>Name (please print)</th>
<th>Phone #</th>
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SECTION V: SUPERVISOR INFORMATION

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<tr>
<th>Date Supervisor Notified: (Month/Day/Year)</th>
<th>Time Supervisor Notified:</th>
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<th>Principal/Supervisor Name (please print)</th>
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<th>Principal/Supervisor Signature</th>
<th>Date</th>
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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.
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 _________________________________

__________________________________________ Date
Employee’s Signature

__________________________________________ Date
Union Representative’s Signature

Required Attachments: [ ] Related Medical Documentation
[ ] Medical Release

cc: Union Office

(Rev. 2/2012)