Workers' Compensation Policy

1.0 POLICY STATEMENT: The City maintains workers compensation protection for employees that sustain work-related injury or illness while acting in the scope and course of their employment. This protection pays for approved medical expenses within the legal requirements of the workers' compensation act, as well as compensation in lieu of wages for lost time.

2.0 PROCEDURES: New employees coming to work for the City of Johnson City will be provided with a copy of the Workers' Compensation policy along with an acknowledgment form (Form HR120-01) for completion and return to personnel file.

2.1 When an injury has occurred within the scope and course of employment, the employee shall report the injury immediately to his/her supervisor and the employee and the supervisor shall complete a "Report of Employee Injury or Illness" (Form HR120-02). This form shall be delivered to the City's Risk Management office by the injured employee within 24 hours of the occurrence (or the next business day). If the nature of the injury prevents the employee from delivering the report, employee's supervisor shall make arrangements for delivery of the report to Risk Management within the 24-hour deadline.

2.2 When an employee is injured on the job, and that injury is compensable under workers' compensation coverage, he/she may receive workers' compensation benefits for medical costs and disability compensation as provided by law. In addition, the employee may have the option of receiving supplemental pay which, when added to the workers' compensation benefits, shall equal full net pay. This supplemental pay shall be charged to the employee's sick leave until sick leave is exhausted. (If employee has no sick leave accumulated, this time may be charged to vacation leave or compensatory leave.) This workers' compensation supplemental pay will commence at the end of seven days of disability to coincide with the commencement of workers' compensation disability payments (i.e., temporary total disability benefits). The use of sick leave, earned vacation or comp time for the first seven days of disability will be at the option of the employee. If the workers' compensation disability exceeds fourteen days, a portion of the personal leave time used during the first seven days of disability may be reinstated to the employee's account.

2.3 Doctors Certificate - The city reserves the right to request a doctor's certificate from any employee who is returning to work following a work-related accident or illness. Employees who are returning to work must have written clearance from his/her treating physician to perform the essential functions of his/her current job.

2.4 Description as follows:

2.4.1 to determine if the individual meets the ADA definition of "individual with a disability," if an accommodation has been requested;

2.4.2 to determine if the person can perform the essential functions of the job currently held, (or held before the injury or illness), with or without reasonable accommodation, and without posing a "direct threat" to health or safety that cannot be reduced or eliminated by reasonable accommodation; and

2.4.3 to identify an effective accommodation that would enable the person to perform the essential job functions in the current (previous) job, or in a vacant job for which the person is qualified (with or without accommodation)

3.0 RESPONSIBILITY: Risk Management is responsible for the overall administration and communication of this policy. The Director of Human Resources shall assist in the communication of the policy.

APPROVED:

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M. Denis Peterson
City Manager

Original:
Revisions: 05/15/2007

CITY OF JOHNSON CITY

Report of Employee Injury or Illness

This report is for use by all departments of the City of Johnson City and must be completed in full as directed within 24 hours of an injury or illness.

To be completed by the injured or ill employee:

Name of Employee:____

Social Security No.:______________________Employment Date:______________________

Job Classification:______________________________Department:______________________

Date of Accident:________________________Location:______________________________

Time of Accident:____________________________________Day of Week:____________________

Description of what happened (be specific):______________________________________

____

Nature of injury of illness and body part(s) affected:__________________________________

____

Immediate working conditions at the time of the injury or illness:

WEATHER CONDITIONS	(check)		SAFETY EQUIPMENT BEING UTILIZED	YES	NO	NOT AVAILABLE
Temperature	________		Hard hat	______	______	__________
Fog	________		Safety boots	______	______	__________
Rain	________		Glasses/shield	______	______	__________
Snow	________		Gloves	______	______	__________
Other conditions	________	(specify)	Scot pack	______	______	__________
Ice	________		Turnout jacket	______	______	__________
Mud	________		Ear plugs	______	______	__________
Gravel	________		Safety vest	______	______	__________
Smoke	________		Warning signs	______	______	__________
Oil	________		Other	______	______	__________
Other	________		Was assistance necessary?	______	______	__________

In what form was assistance necessary? Other persons ____________equipment________________

Were there other contributing factors to this accident or illness?

____

Was carelessness the cause of this accident?______________________________________

DELIBERATE FALSIFICATION OF THIS REPORT MAY BE GROUNDS FOR DISCIPLINARY ACTION.

SIGNATURE: (of injured employee)______________________DATE:____________________

Form HR 120-02

To be completed by the department head or supervisor:

Was the employee administered first aid? YES ( ) NO ( )

Employee was taken to hospital (circle one)

Franklin Woods Hospital Johnson City Medical Center

Was the employee (circle one) dismissed/admitted?

Did the employee return to work on the day of the injury or illness? YES ( ) NO ( )

How many days is the employee expected to be absent from work due to this injury or illness?__________

Date employee will return to work:____

In your opinion, what caused or contributed to this accident?______________________________________

____

____

Number of working days this employee has missed due to injury during the past year and the type of injury:____

Date this accident was reviewed with the employee involved:_______________________________________

SIGNATURE: ____DATE:______________________________

OTHER COMMENTS:____

____

____

____

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CITY OF JOHNSON CITY

Workers' Compensation Coverage Acknowledgement

I,____have received a copy of the workers compensation policy for the City of Johnson City on this date___________________________.

I understand that this workers compensation protection is for employees that sustain accidental injury or illness while acting in the scope and course of employment and that this protection will pay for medical expenses within the legal requirements of the workers compensation act, as well as compensation in lieu of wages.

I further understand that upon returning to work following a work related injury, I must provide written clearance from the treating physician to perform the essential functions of the current job as follows:

- to determine if the individual meets the ADA definition of "individual with a disability," if an accommodation has been requested.
- to determine if the person can perform the essential functions of the job currently held, (or held before the injury or illness), with or without reasonable accommodation, and without posing a "direct threat" to health or safety that cannot be reduced or eliminated by reasonable accommodation.
- to identify an effective accommodation that would enable the person to perform the essential job functions in the current (previous) job, or in a vacant job for which the person is qualified (with or without accommodation).

______________________ ____

Date **Employee Acknowledgment**