Approved Date: April 24, 2009

By: _____
Office of the City Attorney

City of Norfolk

Prescribed Date: 5/8/09

By: _____
City Manager/Director of Public Safety

Departmental General Order ADM-330
Norfolk Police Department

Subject: Workers' Compensation

Office of Preparation: Strategic Management Division

Supersedes:

1. G.O. 96-016, dated July 20, 2004
2. Memo 03-086, dated June 2, 2003
3. Memo 04-032, dated March 22, 2004
4. Any previously issued directive conflicting with this order

Related Documents:

1. G.O. ADM-335: Infectious Disease Control
2. G.O. ADM-340: Modified Duty
3. G.O. ADM-370: Leave
4. G.O. ADM-390: Additional Time
5. G.O. OPR-140: Special Incident Reports (SI)

Order Contents:

Attachments:

A. Form VWC 1, Workers' Compensation Notice
B. Medical Treatment Plan
C. Panel of Physicians Selection Form
D. Workers' Compensation Pharmacy Procedures
E. PD 943, Workers' Compensation/Injury in the Line of Duty Check Off Sheet
F. VWC Form No. 3, Employer's Accident Report
G. PD 944, Narrative Supplemental Sheet Employer's First Report of Accident
H. Refusal of Medical Treatment or Observation
I. VWC Form No. 4, Agreement to Pay Benefits
J. VWC Form No. 4A, Supplemental Agreement to Pay Benefits
K. VWC Form No. 46, Termination of Wage Loss Award

Bruce P. Marquis
Chief of Police

BPM/sm

Purpose

The purpose of this general order is to establish policies and procedures related to reporting and administration of Workers' Compensation claims, and to outline the proper methods of obtaining medical treatment in cases of occupational injury or disease.

Policy

The City of Norfolk is self-insured for Workers' Compensation coverage. The Workers' Compensation program is administered through the Human Resources Department under the Safety, Health and Disability Management Office. Claims handling and medical payment are provided by a third party administrator.

It is the policy of the City of Norfolk and the Norfolk Police Department to ensure:

A. All employees with injuries arising out of, and in the course of, their duties with the City are provided with the appropriate medical care necessary to maximize recovery.

B. All cases which are potentially compensable under the Workers' Compensation Act are thoroughly reviewed to determine whether they are compensable under the Act.

C. A copy of the Form VWC 1, Workers' Compensation Notice, Attachment A, will be posted in a conspicuous place in each command. Workers' Compensation forms and information will be available on the City's computer network.

I. Medical Care Procedures

A. Injured employees will notify a supervisor as soon as possible of any work-related injury or occupational illness. Employees who do not make this notification and later file a claim will have their disability coverage, if approved, start from the date of the initial visit to the City authorized medical facility or physician. Coverage will not be back dated.

B. Employees are not to report to their private physicians for treatment of a work-related injury. In such cases, claims and lost time will not be covered by Workers' Compensation.

C. Initial treatment

1. A City of Norfolk Medical Treatment Plan, Attachment B, will be utilized to obtain medical care. The top section of the treatment plan will be completed by the injured employee unless incapacitated, in which case the supervisor or command representative will complete the form. The date of injury must be recorded on the treatment plan, which will be presented to

the medical facility prior to treatment.

2. If circumstances prevent the completion of a treatment plan prior to the employee's initial treatment, it must be filled out as soon thereafter as possible.

3. The injured employee is responsible for obtaining the completed treatment plan from the physician rendering initial treatment and submitting it to the supervisor handling/submitting the Workers' Compensation check off sheet and forms.

D. Authorized medical facilities

1. The following medical facilities are recognized and authorized by the City of Norfolk for use by employees who are injured during the performance of their assigned duties to obtain <u>initial</u> treatment:

a. Hospital emergency rooms: Personnel with serious or life-threatening injuries will be taken to the most appropriate hospital emergency room that provides care for the type of injury sustained, and/or in the case of paramedical rescue transportation, the emergency room deemed most appropriate by a member of that staff. Examples of such injuries include, but are not limited to, the following:

(1) Severe head injury

(2) Severe fracture

(3) Severe burn

(4) Severe laceration

(5) Eye injury

(6) Severe chest pains or difficulty breathing

(7) Severe pain (e.g., back pain that goes down the leg(s))

b. Medical care centers: Personnel with less serious injuries will be taken to the nearest medical care center, identified in the City of Norfolk Panel of Physicians Selection Form, Attachment C, during the hours the facilities are open. Examples of these injuries include, but are not limited to, the following:

(1) Minor lacerations

(2) Bruises and contusions

(3) Chipped teeth

(4) Skin irritations

(5) Insect bites

Employees using emergency rooms for treatment of minor injuries instead of medical care centers may be held liable for the medical bills incurred by such treatment. However, if employees are at a hospital emergency room on other related matters, such as a prisoner injury treatment, then they may use emergency rooms for minor injuries. An explanation for the emergency room treatment of minor injuries must be included with forwarded paperwork.

c. In the event the emergency care centers are closed, personnel will use the following hospital emergency rooms:

(1) Sentara Norfolk General Hospital

(2) Sentara Leigh Memorial Hospital

(3) DePaul Hospital

d. The medical facility designated in G.O. ADM-335: Infectious Disease Control, will be used for cases involving exposure to airborne and/or bloodborne pathogens.

e. In the event department personnel are injured and require immediate treatment while conducting police business (i.e. training, investigations, or prisoner transports, etc.) outside the City of Norfolk, they may go to the nearest medical facility. A supervisor from the employee's assigned command should be notified as soon as possible. Follow-up treatment will be in accordance with Section I.E. below. All required reports and/or forms as detailed in Section II of this order will be filed for the injury.

E. Follow-up medical treatment

1. When the physician rendering initial treatment indicates that follow-up treatment is required, the command secretary or administrative staff will assist the employee in selecting an authorized Workers' Compensation physician.

2. Only those physicians on the list provided by the Safety, Health and Disability Office and maintained by the command secretary or administrative staff are authorized to provide follow-up treatment to employees with injuries arising out of and in the course of their duties with the City.

3. Follow-up treatment by a physician not found on the list and not coordinated via the command secretary or administrative staff will not be paid for by the City unless it is arranged through, and approved by the Safety, Health and Disability Management Office prior to obtaining such treatment.

4. When an employee has selected an authorized physician to provide necessary follow-up treatment, that physician becomes the attending physician.

5. A City of Norfolk Medical Treatment Plan will be completed and returned to the employee's command for each follow-up appointment and forwarded to the Personnel Liaison Division (PLD).

F. Employees who have been released to modified duty, but are unable to report to work, must contact their command secretary or administrative staff, and report to the attending physician or City-approved contract physician, e.g., NOWCARE, to be placed on authorized Injured in the Line of Duty (ILD) absence. Otherwise, these employees must use approved leave.

G. Change in condition

1. If additional medical treatment is necessary due to a change in the employee's physical condition following the attending physician's release of the employee to unrestricted or modified duty, the employee must:

   a. Return for such medical treatment to that physician. Employees may contact the City's Third Party Administrator (or if assigned the disability case manager) if an alternate physician is requested.

b. Prior to obtaining such medical treatment, and with the assistance of the command secretary or administrative staff, select an appropriate physician from the City of Norfolk Panel of Physicians Selection Form.

2. A City of Norfolk Medical Treatment Plan will be obtained prior to treatment, then completed and forwarded to PLD via the employee's command for each follow up appointment.

H. Employees filling Workers' Compensation related prescriptions will follow City of Norfolk Workers' Compensation Pharmacy Procedures, Attachment D. A list of pharmacies providing prescription medication to personnel involved in Workers' Compensation-related injuries, when such medication is prescribed by an authorized treating physician selected in accordance with this section, will be published as memoranda and updated as required.

II. Reporting Procedures

A. Initial reporting: Employees will notify a supervisor as soon as possible of any work- related injury. Supervisors will complete the appropriate paperwork located in a Workers' Compensation/Injury in the Line of Duty, Accident packet, assembled by each command, when completing all Workers' Compensation related claims. The Workers' Compensation point of contact in the Police Department is the employee's command secretary or administrative staff. For questions and/or issues that cannot be resolved by the employee's command, they may contact the PLD or Safety, Health and Disability Management Office for additional information, direction, or advice.

1. PD 943, Norfolk Police Department, Workers' Compensation/Injury in the Line of Duty Check-Off Sheet**,** Attachment E, will be used in conjunction with other appropriate forms as required for work-related illness or injury and workers' compensation matters. A PD 943 will be used for all initial and follow-up reporting to include submission of treatment plans. All commands will follow the procedures listed on the form. Employees/supervisors completing or processing the PD 943 will annotate the form in the spaces provided, i.e., initials, control number, and date. All appropriate forms will accompany the PD 943.

a. Any injury in the line of duty, exposure to blood, exposure to body fluids, exposure to blood borne pathogens, or exposure to airborne pathogens will be reported using a PD 943 and other appropriate forms prescribed for work-related illness or injuries, and in accordance with G.O. ADM-335: Infectious Disease Control. These injuries or exposures **alone** do not require the submission of PD 539, Notification of Special Incident. A PD 539 is required for incidents involving Assault on a Police Officer, Discharge of

Firearm, Forced Entry, Use of Force, and Injury to Prisoner. However, if any of these incidents cited above involve injury to or exposure of an employee, PD 539 and PD 943 with appropriate accident forms will be completed and filed separately.

b. Although illness, injury, or exposure may be related to an incident requiring a PD 539, these matters will be reported separately. The narrative for a PD 539 will detail the circumstances of the incident in matters relevant to the subject area requiring the submission. Injuries or exposures may be noted on the PD 539 as occurring, although in-depth detail of the injury or exposure is not required e.g. "while making arrest exposed to blood of suspect from abrasion on suspect's left hand." Conversely, injuries or exposures that require the submission of a PD 539 may note on the VWC Form No. 3 Employer's Accident Report or the PD 944 that the officer was injured or exposed during an incident (e.g. making an arrest) but need not detail all facts and circumstances leading up to and occurring during the incident.

c. The narrative from a PD 539 will not be copied and used for an injury, accident, or exposure, nor will the narrative from a VWC Form No. 3 Employer's Accident Report or PD 944 be used for an incident requiring a PD 539.

2. Employer's Accident Report

a. Information regarding the circumstances surrounding a work-related injury will be prepared and submitted by the injured employee's immediate supervisor on the VWC Form No. 3, Employer's Accident Report, Attachment F. This report will be prepared and forwarded regardless of whether the supervisor agrees or disagrees with the employee's claim of injury. The report of injury shall be faxed immediately upon completion to the third party administrator. Current fax telephone number is listed on the PD 943.

b. When preparing the VWC Form No. 3, Employer's Accident Report, supervisors will use a beige colored form, and follow the instructions on the reverse side of the form.

c. An example of VWC Form No. 3, Employer's Accident Report, Attachment F, has been partially completed with information that does not change from report to report, and other blocks contain annotations indicating who is responsible for filling in those blocks.

d. The employee's average weekly wage is based on wages earned for the past 12 months prior to the date of the work-related injury or occupational illness, and includes overtime and special allowances.

3. PD 944 Norfolk Police Department, Narrative Supplemental Sheet Employer's Accident Report, Attachment G, will be used, as necessary, to provide additional, supplemental, or detailed information about an accident, injury or exposure. A PD 944 will be used as necessary in conjunction with the VWC Form No.3, Employer's Accident Report.

4. A City of Norfolk Medical Treatment Plan will be utilized when obtaining medical care for a work-related injury or occupational illness. The form, once completed by the treating physician or health care provider, will be returned by the employee and included with the forwarded paperwork.

5. Refusal of Medical Treatment Form, Attachment H is used when an employee receives a work-related injury and, at the time of the injury, declines medical treatment. This form does not necessarily affect eligibility for Workers' Compensation. An employee may request authorization for subsequent medical treatment, and consequently will need to adhere to paragraph I.C.

6. VWC Form No. 4, Agreement to Pay Benefits, Attachment I documents an employee's is eligibility for wage payments due to an incapacity for work exceeding seven days as a result of an occupational illness or disease. If an employee is totally disabled from work for eight cumulative calendar days or more, on the eighth day (or first business day thereafter) the command shall immediately notify the third party administrator and the Safety, Health and Disability Management Office to activate Workers' Compensation payments.

7. Command secretaries or administrative staff will review the submitted paperwork for completeness, copy the forms as necessary, and forward the package via the chain of command to the appropriate bureau chief. After review and processing by the bureau chief, paperwork will be forwarded to the Personnel Liaison Division for monitoring and filing.

B. Reporting for Change in Condition

1. If the employee, after returning to work, must again leave work due to the injury, the command secretary or administrative staff will contact the third party administrator so the following forms can be completed:

a. VWC Form No. 4A Supplemental Agreement to Pay Benefits, Attachment J will be completed only in cases where there are

intermittent periods of incapacity, and compensation has been paid, or if there is a permanent disability for which the employee will be compensated for specific periods as provided by the Workers' Compensation Act.

b. VWC Form No. 46, Termination of Wage Loss Award, Attachment K, documents termination of an employee's eligibility for Workers' Compensation wage indemnity payments.

2. Completed forms will be forwarded by the command secretary or administrative staff to the third party administrator, with copies sent to the Safety, Health and Disability Management Office and the Personnel Liaison Division.

III. Chronic Occupational Injuries, Illness or Disease Claims

Examples of these claims may include, but are not limited to, cumulative trauma, hearing loss, carpal tunnel syndrome, hypertension, infectious/bloodborne diseases, heart disease and lung disease. These claims are unique in that there is not an immediate cause of injury associated with a specific, identifiable workplace event that occurred at a specific time and place. Therefore, until a claim is thoroughly researched to determine whether the injury is compensable under the Virginia Workers' Compensation Act, employees will not be authorized by the City of Norfolk to utilize medical facilities/physicians specified in Attachment C. These claims will be handled as follows:

A. Upon discovering that an employee has suffered a chronic injury, illness or disease that they believe may be work-related, the employee shall immediately complete an Employer's Accident Report. The employee shall include in block 42 of the report all potential work-related causative factors that may have contributed to their illness or injury. A PD 943 and PD 944 will be completed as appropriate.

B. The employee shall attach a signed City of Norfolk Release for Medical Authorization (obtained from command secretaries or administrative staff) to the Employer's Accident Report along with a form identifying all of their physicians for the past 20 years. This information shall be faxed to the third party administrator before a claim review will be started. The originals are to be forwarded to the Safety, Health and Disability Management Office with copies sent to the Personnel Liaison Division.

C. Employees should notify all of their treating physicians that record requests and questions from the third party administrator must be responded to promptly to assist in the evaluation of the claim. Final disposition of the claim cannot be made until all the requested medical information is received.

D. Employees will utilize their own personal health care insurance for all medical treatment for these cases until a determination of compensability is made. If the

claim is accepted, receipts documenting proof of payment may be submitted to the City for reimbursement.

IV. Leave Utilization Pending Determination of Compensability

A. Pending an official determination of compensability, employees who are absent from work, for treatment or convalescence, due to a potentially job-related injury or illness, must use accrued annual leave and/or sick leave or other compensatory leave so as to continue to receive their regular pay during such absence. If necessary, participants in the Sick Leave Bank may request coverage. If all such entitlements are exhausted before the determination is made, then leave without pay (LWOP) must be requested.

B. Chronic occupational injury, illness or disease claims often move slowly if not pursued diligently. It is in the best interests of all parties to keep abreast of events and promptly furnish necessary documentation. Determinations are not possible until physicians' statements and other documents are on hand; therefore, employees are urged to expedite completion and submission of all required documentation.

V. Leave after Compensability Has Been Determined

A determination that the occupational injury, illness or disease is/was not compensable will enable leave arrangements to be finalized and payment for any medical treatment will become the responsibility of the employee through the employee's regular health care program.

A determination that the occupational injury, illness or disease is/was compensable under the Workers' Compensation Act will result as follows:

A. All leave taken of whatever type relating to periods of disability will be restored.

B. Medical costs from authorized treating physicians, as set forth in section I above, will be borne by the City, to include reimbursement of health care program and employee payments.

C. Time spent at future medical appointments will be deemed to be on-duty:

1. Medical appointments should be made during an employee's scheduled working hours and will not require deduction of any sick or other leave.

2. When approved, appointments scheduled during off-duty hours, other than ILD, will earn compensatory time if the employee is a nonexempt employee as defined by the Fair Labor Standards Act (FLSA). If the employee is exempt as defined by the FLSA, then a schedule adjustment will be made in accordance with the provisions of G.O. ADM-390:

Additional Time.

VI. Workers' Compensation Payment Procedures

A. That portion of an employee's wages paid by Workers' Compensation is not subject to payroll taxes, while the supplement provided by the City is subject to deductions.

B. Employees on Workers' Compensation will receive two checks instead of one.

1. The third party administrator will send one check for two thirds of the employee's pay from the Workers' Compensation fund.

2. The second check will be paid by the employee's department and will contain one third or the remaining pay equal to the employee's net pay. All deductions will be made from the department check, because deductions are prohibited from the Workers' Compensation check. Thus any deductions exceeding the amount of the department check will require the employee to make their own payments for such deductions as long as the employee is on Workers' Compensation.

C. The department's personal services budget will be charged only for the City's supplemental pay.

D. If a pending claim, such as those specified in section III above, is accepted, payroll will update its records to provide the employee non-taxable income status for the Workers' Compensation monies owed, including a corresponding tax adjustment.

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

City of Norfolk
Medical Treatment Plan
Worker's Compensation Injury

Date of Injury:

Employee Information:
Employee Name: _____SS#_____
JobClassification:_____Dept/Bureau:_____
Supervisor/DMC: Name & initials:_____ Phone:_____
InjuryType:_____DOB**:**_____
Panel Physician Name:_____Phone:_____

EVERY EFFORT WILL BE MADE TO ACCOMMODATE MODIFIED DUTY EITHER IN THE DIVISION OR OUTSIDE THE DIVISION.
Report of Physician:
Nature of Injury/condition:_____
Referred to:_____(for additional medical care)
Release Status:
-Full Duty _____
-Projected date of full duty return to work: _____
-No Duty_____NextAppointmentDate:_____
-Modified Duty: _____Next Appointment Date:_____
Level: Sedentary Light:_____Medium:_____Heavy:_____

Physical Capacities:
Please circle YES/NO as appropriate. Indicate hours per day allowed as needed. Note that some City of Norfolk employees work 10-hour days or 24-hour shifts.

Task	**Status**		**Number of Hrs./Comments**
Standing	yes	no	___ hours per day _____
Pushing/pulling	yes	no	___ hours per day _____
Sitting	yes	no	___ hours per day _____
Use of Hands	yes	no	___ hours per day _____
Lifting	yes	no	___ hours per day _____
Stooping/bending	yes	no	___ hours per day _____
Walking	yes	no	___ hours per day _____
Reaching	yes	no	___ hours per day _____
Climbing stairs/ladders	yes	no	___ hours per day _____
Operation of Commercial Vehicle /Equip. for work	yes	no	___ hours per day _____

Comments:_____
_____
_____

_____ _____
Physician Signature Date

City of Norfolk
Panel of Physicians Selection Form

The City of Norfolk provides the following panel of physicians to its employees for treatment of workers' compensation injuries. Under the Virginia Workers' Compensation Act, you must select your treating physician from this panel. This form is provided to assist you with that selection. If you choose a treating physician who is not on this list, you may be responsible for the cost of medical care.

1. Notify your supervisor of your illness or injury. The injury/ illness should also be shown on the VWC3, Employer's Accident Report.
2. Tell your doctor the City's Workers' Compensation Program is administered by CompManagement, Inc.
3. For emergencies, use any physician. After your initial emergency treatment, select a doctor from the panel.
4. Take the Medical Treatment Form to the selected panel physician.

USE ONE OF THESE PHYSICIANS FOR WORK RELATED INJURY.

Bayview Medical Center
7924 Chesapeake Blvd.
Norfolk, VA 23518
(757) 587-1700
Office Hours:
Monday – Friday 8am to 8pm
Saturday 9am to 3pm

Doctors:
Dr. Michael Webb
Dr. Lynette Rogers

NDC Medical Center
850 Kempsville Road
Norfolk, VA 23502
(757) 466-5900
Urgent Care / Office Hours:
Monday – Friday 8am to 7pm
Saturday 9am to 5pm
Sunday 9am to 5pm

Doctors:
Dr. David M. Cundriff
Dr. Zarine Mistry
Dr. William L. Robinett

I&O Medical Centers
1290 Diamond Springs Rd.
Va. Beach, VA 23455
(757) 460-0700
Office Hours:
Monday – Friday 8am to 6pm
Saturday 9am to 1pm

Doctors:
Dr. Joan Lingen
Dr. Michael Baddar

Taylor Made Diagnostics
1228 Progressive Drive
Chesapeake, VA 23320
(757) 548-9771
Office Hours:
Monday – Thursday 0830 to 5pm
Friday 0830 to Noon

Taylor Made Diagnostics
1001 Poindexter Street
Chesapeake, VA 23324
(757) 494-1688
Office Hours:
Monday – Friday 0830 to 5pm

Now Care Med. Ctr. II
6632 Indian River Road
Va. Beach, VA 23464
(757)424-4300
Office Hours:
Monday – Friday 8am to 8pm
Saturday 9am to 3pm
Sunday 9am to 3pm

Doctors:
Dr. T. Ebenshestry
Dr. J. Shaughnessy
Dr. A. Cetrone

For personnel working Suffolk reservoirs or pipeline
Lakeview Urgent Care
2000 Meade Pkwy.
Suffolk, VA 23434
(757) 934-9366
Office Hours:
Monday – Friday 7am to 5pm
Saturday 8am to Noon

I have been provided the above panel subsequent to my worker's compensation injury and have selected

_____ (group/practice) from the panel.

_____ _____
Date Employee Signature

Workers Compensation Pharmacy Procedures

The City of Norfolk's Third Party Administrator for Workers Compensation, Comp Mgt., has a contract with Modern Medical, Inc. to pay for all workers compensation related prescriptions with a built in discount. Modern Medical has a contract with all the major pharmacies in the State of Virginia (see attached list).

Prescription Fill Process for Work Related Injuries:

1. Immediately FAX the First Report to Comp Management at 1-804-673-5400.
2. Comp Mgt. will notify Modern Medical electronically that the claim is approved (unless the claim is a chronic related illness such as a heart or lung illness etc. which requires a different procedure).
3. The employee upon arriving at the Pharmacy will identify themselves as a City of Norfolk employee covered for WC prescriptions by Modern Medical.
4. The pharmacy will look up the employees name by their social security number on the Modern Medical web site to see if approval has been granted and then fill the prescription..
5. For significant injuries requiring long term care exceeding two or more weeks, Modern Medical will issue the employee a prescription card. The card is limited to the WC authorized treating physician and medications that relate to the treatment of the occupational injury.

The above process must be followed in order to obtain approved prescriptions. Failure to promptly fax the Employer's Accident Report form to Comp Mgt. will result in the pharmacy's inability to fill a prescription due to a lack of authorization.

Failure to Receive Authorization - Alternate Prescription Procedures:

An alternative prescription procedure has been provided for employees that work outside of normal work hours of Comp Mgt. and Modern Medical, particularly for Public Safety, Night Crews and others that work other than standard day hours. This process may also be utilized by employees who for some reason are not in the Modern Medical system.

Through Modern Medical and Comp Mgt., Walgreens Pharmacy at Wards Corner (115 West Little Creek Rd, 489-5291) will fill prescriptions that are not in the Modern Medical system through the procedure listed below (Note that the **Wards Corner Walgreens is a 24 hour Pharmacy**):

1. Follow the procedures listed in 1 – 5 above first.
2. If the pharmacy determines that you are not in the Modern Medical system (particularly if the injury occurred after regular business hours), provide the pharmacist a copy of your medical authorization form, prescription and present a picture ID that is either a driver's license or City ID card.
3. The Pharmacist will then process the prescription by utilizing an Modern Medical Temporary Prescription Services ID form that is exclusively for City of Norfolk employees for temporary authorization to fill a prescription.
4. The Temporary Prescription ID form will be forwarded to Modern Medical for payment.
5. For a second or additional prescription refill, please follow the process listed in 1 – 5 in the first section. If the pharmacy cannot fill the prescription because you are not in the Modern Medical system, you may again utilize the Temporary Prescription Services ID procedure. However, call the City's Disability Management Office at 664-4495 or Comp Mgt. at 1-800-368-8002 so that we can determine why you are still not in the system.

PD 943

NORFOLK POLICE DEPARTMENT
WORKERS COMPENSATION/INJURY IN THE LINE OF DUTY CHECK OFF SHEET

☐ Initial Injury Submission
☐ Follow-up Submission

When any of the below listed forms are completed, a new check off sheet must accompany their submission (i.e. when employee returns to full duty, next doctor's appointment, etc.). **Note: this is ILD injury only, if Assault on Police Officer, Use of Force, or Injury to Prisoner occurred, you must file Special Incident Report separately from this Check Off Sheet in accordance with General Order 86-009.**

Injured Employee's Name: _____ Control Number: _____

Command: _____ Date of Injury: _____ Time of Injury: _____

Location of Incident: _____

The following forms are to be submitted with this report and routed as described.

IMMEDIATE/FIRST LINE SUPERVISOR	**INITIALS/CONT. #**	**DATE**
Complete Employer's Accident Report (VWC form #3 rev 03/22/02). **Do not attach a copy of the Special Incident Report to this form**. In block **#29** list employee's Division as well as the word "Police". In blocks **#42 and 43** do not put "refer to Special Incident Report". These two blocks must be filled out thoroughly and completely. Use the Narrative Supplemental Sheet (PD 944) if necessary.		
1. Complete Refusal of Medical Treatment or Observation **or** Panel of Physicians Form and Medical Treatment Plan.		
2. **Immediately** fax a copy of the Employer's Accident Report Form and any subsequent Medical Treatment Plans to: a) Safety, Health and Disability Management 664-4078 b) CompManagement (Attn: Claims Representative) (804) 673-5400		
**** Write the date and time the Employer's Accident Report Form was faxed in the upper right hand corner of report and attach confirmation sheet if possible**		
4. Route all paperwork to command secretary.		

COMMAND SECRETARY		
1. Photocopy Employer's Accident Report, Refusal of Medical Treatment or Observation, or Panel of Physicians Form and Medical Treatment From and **forward the originals to:** Human Resources (Safety, Health and Disability Management) Attn: Safety Officer 664-4495 or 664-4491		
****Notify Human Resources (Safety, Health and Disability Management) immediately upon the eighth day of total disability.**		
2. Forward copies of all completed paperwork to Commanding Officer.		
3. Forward copies of all completed paperwork to Bureau Secretary.		
4. Notify Human Resources (Safety, Health and Disability Management) upon return to Full Duty.		

BUREAU SECRETARY		
1. Review of all completed paperwork by Bureau Chief.		
2. Forward copy of the Employer's Accident Report Form, Refusal of Medical Treatment or Observation or Panel of Physicians Form and Medical Treatment Form to Personnel Liaison Division.		

PERSONNEL LIAISON DIVISION		
1. Confirm forms received by:		
a. CompManagement		
b. Safety, Health and Disability Management		
2. File in employee medical folder		

@@ = Supervisor Complete
* = CompManagement complete
= Command Secretary complete

FAXED:
DATE: TIME:

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)
City of Norfolk - Police		
4. Mailing address Safety & Disability Management 810 Union Street, Norfolk, VA 23510	5. Location (if different from mailing address)	
6. Parent corporation /Policy Named Insured (if applicable) or PEO name	7. Nature of business Police Protection	
8. Name and Address of Insurer or self-insurer for this claim Self-insured	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 @@ a.m. ☐ p.m. ☐ 13a. Time began work @@ a.m. ☐ p.m. ☐	14. Date of incapacity	15. Hour of incapacity
@@	@@			
16. Was employee paid in full for day of injury? ☒ Yes ☐ No		17. Was employee paid in full for day incapacity began? ☒ Yes ☐ 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 @@ ☐ Male ☐ Female
@@	@@	
25. Address @@	26. Date of birth @@	27. Marital status @@ ☐ Single ☐ Divorced
	28. Social security number @@	☐ Married ☐ Widowed
29. Occupation at time of injury or illness @@	30. Is worker covered by PEO policy? * ☐ Yes ☐ No	31. Number of dependent children ☐ @@
32. How long in current job? @@	33. Date of Hire ##	34. Was employee paid on a piece work or hourly basis? * ☐ Piece work ☐ Hourly
35. Hours worked per day ☐ @@	36. Days worked per week ☐	37. Value of perquisites per week * Food/meals $ Lodging $ Tips $ Other $
38. Wages per hour $ ##	39. Earnings per week (inc. overtime) $ *	

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? ☐ Yes @@ ☐ No 43b. Treated in Emergency Room? ☐ Yes ☐ No	
44. Physician (name and address) @@	45. Hospital or Clinic (name and address) @@	
46. Probable length of disability	47. Has employee returned to work? ☐ Yes ☐ No	If yes: 48. At what wage? * / 49. On what date? *
50. EMPLOYER: prepared by (name, signature, title) Bruce P. Marquis, Chief of Police	51. Date	52. Phone number 664-3297
53. INSURER: (name of processor) *	54. Date	55. Phone number
56. THIRD PARTY ADMINISTRATOR (if applicable) CompManagement	57. Address P.O. Box 85631 Richmond, VA. 23285	58. Phone number 1-800-368-8002

Supervisor: Officer: Commanding Officer:

PD 944

NORFOLK POLICE DEPARTMENT
NARRATIVE SUPPLEMENTAL SHEET
EMPLOYER'S FIRST REPORT OF ACCIDENT

Use this form as a supplemental attachment with the Employer's First Report of Accident to help fully explain the circumstances surrounding the injury of the below named employee.

Injured Employee's Name: _____ Control Number: _____

Command: _____ Date of Injury: _____ Time of Injury: _____

Location of Incident: _____

Narrative/Supplemental information

_____

_____
Employee Signature

_____
Date

_____
Supervisor Signature

_____
Date

City of Norfolk

REFUSAL OF MEDICAL TREATMENT OR OBSERVATION

Employee's Names: _____

Date of Accident: _____

Supervisor: _____

Witness(es): _____

Job being performed at time of injury:

_____

Nature of Injury: _____

I, _____, hereby acknowledge my refusal of medical
(employee name)
treatment and/or observation offered to me at the expense of the City of Norfolk for my injury during working hours on _____(date). By signing this form, I realize that I do not necessarily affect my later eligibility for Workers' Compensation, but only acknowledge that my supervisors in good faith have offered and made available to me an opportunity to obtain necessary medical treatment and /or Observation. I understand that at a later time I may request from my supervisors a medical authorization to obtain medical treatment an/or observation for the above- described injury, which request then can either be approved or denied.

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

Agreement to Pay Benefits

(formerly: Memorandum of Agreement)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
SEE INSTRUCTIONS ON REVERSE SIDE

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code/PEO Ref. #	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's First Report)	Address
Phone number / Federal Tax Identification Number	Is this worker covered by PEO policy? ☐ Yes ☐ No

Employee

Name of employee	Phone number
Address	Date of birth
	Social security number

Time and Place of Accident

City or county where injury or illness occurred	Cause of injury or illness

Nature of injury or illness, including parts of body affected

Date of injury or illness	List first seven days of incapacity	Pre-injury Average Weekly Wage

Terms of Agreement

We certify that the facts relating to this accident are correct as presented on this form, and agree that the employee shall receive the compensation or benefits indicated below until terminated in accordance with the provisions of the Workers' Compensation Act.

Temporary Total — **$_____ shall be paid per week beginning _____ based on a pre-injury average weekly wage of $_____.**

Temporary Partial — **$_____ shall be paid per week beginning _____, the date on which claimant returned to work at a weekly wage of $_____ compared to a pre-injury average weekly wage of $_____.**

Permanent Partial — **$_____shall be paid per week for _____ weeks beginning _____, based on a _____% loss (or loss of use) of the _____, and a pre-injury average weekly wage of $_____. This compensation shall be payable _____.**

Medical only — **_____ (Check here.) The parties agree to an award for payment of medical bills related to the compensable injury.**

Signatures

	Print Name	Phone	Date
Employer		( )	/ /
Employee, guardian, or committee		( )	/ /
Insurer or authorized representative (signature of processor)		( )	/ /

Name and address of Insurer	(This space reserved for Commission use)
Name and address of employee's attorney (if represented)	Fee Approved by Date

This report is required by the Virginia Workers' Compensation Act

Agreement to Pay Benefits
VWC Form No. 4 (rev. 9/1/99)

Supplemental Agreement to Pay Benefits

(formerly: Supplemental Memorandum of Agreement)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON REVERSE SIDE

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's First Report)		Address
Phone number	Federal Tax Identification Number	

Employee

Name of employee		Phone number	Cause of injury/ illness
Address		Date of birth	Nature of injury/ illness(incl. body parts)
		Social security number	City or county where injury/illness occurred:
Date of injury or illness	List first seven days of incapacity	Pre-injury Average Weekly Wage	

Temporary Total

$_____ shall be paid per week during total incapacity, beginning ____/____/____.

Temporary Partial

$_____ shall be paid per week during partial incapacity beginning ____/____/____, based on a current weekly wage of $_____, compared to a pre-injury average weekly wage of $_____.

Permanent Partial

$_____ shall be paid per week for a period of _____ weeks beginning ____/____/____, based on _____% loss (or loss of use) of the _____, payable _____.
(body part) (payment interval)

Employer	Print Name	Phone	Date
		( )	/ /
Signature of Employee, guardian, or committee	Print Name	Phone	Date
		( )	/ /
Insurer or authorized representative (signature of processor)	Print Name	Phone	Date
		( )	/ /
Name of Insurer	(This space reserved for Commission use) Fee		
Name and address of employee's attorney (if represented)	Approved by	Date	

This report is required by the Virginia Workers' Compensation Act

Supplemental Agreement to Pay Benefits
VWC Form No. 4A (rev. 9/1/99)

Termination of Wage Loss Award

(formerly: Agreed Statement of Fact)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's First Report)		Address
Phone number	Federal Tax Identification Number	

Employee

Name of employee		Address
Phone number	Social Security Number	

Terms of Agreement

Payments of compensation under the outstanding award for the accident occurring on _____ are terminated for the reason indicated below.

1. ☐ **The employee returned to work on _____ at a wage equal to or greater than the pre-injury average weekly wage of $_____.**

2. ☐ **The employee was able to return to his/her pre-injury work on _____.**

3. ☐ **The employee returned to work on _____ at a lower-than-pre-injury wage in the amount of $_____. (A Supplemental Agreement to Pay Benefits must be attached and the outstanding award will be terminated and an award for temporary partial benefits will be entered.)**

TOTAL AMOUNT OF COMPENSATION PAID THROUGH ABOVE DATE $ _____

TOTAL COST OF LIVING ADJUSTMENT PAID THROUGH ABOVE DATE $ _____

This agreement is subject to the Commission's approval. Signing this form is NOT a requirement for payment of compensation, and does not terminate the right to future compensation. See "Employee" section on the reverse of this form.

(This space for Commission use only)
Approved by: Date:

(This space reserved for use by the insurer or employer)

Payment type	Compensation rate	Beginning date	Ending date	Total weeks paid	Amount paid
_____	$ _____	_____.	_____.	_____	$ _____
_____	$ _____	_____.	_____.	_____	$ _____
_____	$ _____	_____.	_____.	_____	$ _____
_____	$ _____	_____.	_____.	_____	$ _____

Signature of Employee, guardian, or committee	Date	Print Name	Phone ( )
Insurer or authorized representative (signature of processor)	Date	Print Name	Phone ( )
Name of Insurer		Third Party Administrator and Address (if applicable)	

Termination of Wage Loss Award
VWC Form No. 46 (rev. 9/1/99)