

# Workers Comp Claim Checklist

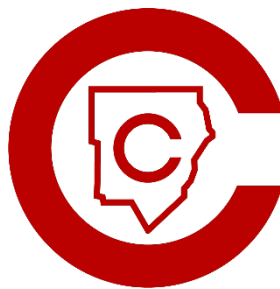
**Thank you for using the Worker's Comp portal to submit the injured Employee's information.**

Here is a checklist of forms that should be uploaded before submitting the claim.

- **Employee Injury Form** – Filled out entirely, signed and dated by Employee & Supervisor
- **Medical Release form** – Signed and dated regardless of whether employee is seeking medical treatment.
- **Declination Form** – Signed and Date only if Employee is **NOT** seeking immediate medical treatment.
- **Panel of Physicians** – Employee should circle choice of clinic and initial & date.
- **Worker's Comp Bill of Right's** – Employee should initial and date top of document.

**If you forget to upload any of these documents, please fax or email to [678-594-8585](tel:678-594-8585) or [RiskManagement@cobbk12.org](mailto:RiskManagement@cobbk12.org) immediately.**

Please keep original documents and provide copy to employee if requested. Employee injury paperwork should be kept separate from personnel folder. Workers Compensation documents are considered privileged information and should not be shared unless approved by Risk department.



THIS FORM MUST BE COMPLETED IN ITS ENTIRETY INCLUDING SIGNATURE AND DATE

COBB COUNTY SCHOOL DISTRICT  
EMPLOYEE INJURY FORM

Office (770)426.3342

Fax (678)594.8585

Employee \_\_\_\_\_ SS# \_\_\_\_\_ Employee# \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Contact # \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eye Color \_\_\_\_\_ Hair Color \_\_\_\_\_ Marital Status \_\_\_\_\_

Hand Dominance Left \_\_\_ Right \_\_\_\_\_

School/Dept. \_\_\_\_\_ Job Title \_\_\_\_\_ Accident Date \_\_\_\_\_ Time \_\_\_\_\_

Date Reported to Supervisor \_\_\_\_\_ Accident Location \_\_\_\_\_  
*(i.e. hallway, cafe, etc.)*

Body Part(s) Injured \_\_\_\_\_ Describe the Accident \_\_\_\_\_  
*(i.e. upper back, right foot, etc.)*

\_\_\_\_\_  
\_\_\_\_\_

Witnesses \_\_\_\_\_ Tel# \_\_\_\_\_

Medical Treatment \_\_\_\_\_ Yes (IF YES TREATMENT MUST BE SOUGHT WITH APPROVED PANEL PHYSICIAN)  
\_\_\_\_\_ No (IF NO, DECLINATION FORM MUST BE SIGNED)

Name of Treating Facility \_\_\_\_\_

Taken via Ambulance \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Left Work Due to Injury \_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

**Acknowledgment** - I have received & initialed the Panel of Physicians indicating my choice \_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

**Prior Medical Treatment?**

Have you had prior injury or condition to injured body part(s) Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, explain

\_\_\_\_\_  
\_\_\_\_\_

**How Can Future Accidents Be Prevented? (Mark all that apply)**

Employee Training \_\_\_\_\_ Proper Use of Equipment \_\_\_\_\_ Improve Task Procedures \_\_\_\_\_ Improve Work Area \_\_\_\_\_  
Provide Hazard Warning \_\_\_\_\_ Equipment Correction \_\_\_\_\_ Removal of Hazard \_\_\_\_\_ Use of Personal Protective Equipment \_\_\_\_\_  
Enforce Policy/Rule \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTE: CONTACT RISK MANAGEMENT WITH ANY QUESTIONS AT [RISKMANAGEMENT@COBBK12.ORG](mailto:RISKMANAGEMENT@COBBK12.ORG)**

**\*Please return form to supervisor and maintain a copy for your records**

# Cobb County School District

## Medical Release Form

Office (770) 426-3342

Fax (678) 594-8585

### THIS FORM MUST BE SIGNED AND DATED

#### Release of Medical Information:

I hereby authorize any physician, hospital, pharmacy, any other healthcare facility, and insurance company to use and disclose all records relevant to my injury to CCSD, including, but not limited to, medical diagnosis, prognosis, treatment and periods of hospitalization.

It is understood that the Risk Management Department will use the information to verify my injury and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, clinic, insurance companies, Worker's Compensation carriers and organizations administering benefit programs.

This authorization will remain in effect throughout the lifetime of my claim. A photocopy of this authorization will be as valid as the original. I understand that benefits can not be conditioned solely on whether I sign this authorization form.

I have received a copy of the Bill of Rights for Injured Worker

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Print Name \_\_\_\_\_

NOTE: CONTACT RISK MANAGEMENT WITH ANY QUESTIONS AT [RISKMANAGEMENT@COBBK12.ORG](mailto:RISKMANAGEMENT@COBBK12.ORG)

**\*Please return form to supervisor and maintain a copy for your records**



**HUMAN RESOURCES**  
COBB COUNTY SCHOOL DISTRICT

## **Declination of Medical Treatment for Work Related Injury**

I have reported an injury to my employer that may be work related. Medical Treatment has been offered but I voluntarily decline.

I understand that if I experience symptoms that indicate a need for medical evaluation, I must immediately inform my supervisor and choose a physician from the attached **CCSD Designated Physician Panel**.

I have been provided with information and have had the opportunity to ask questions regarding seeking medical treatment.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

Cc: [RiskManagement@cobbK12.org](mailto:RiskManagement@cobbK12.org)

WC-BILL OF RIGHTS

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

### Employee's Rights

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$533.33 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$533.33 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$800 per week. A widowed spouse with no children will be paid a maximum of \$320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

### Employee's Responsibilities

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: <https://www.sbcw.georgia.gov>. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <https://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

# PANEL OF PHYSICIANS

## OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

### WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY, AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days (see O.C.G.A. § 34-9-80).

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (See Rule 201 for definition of minority physician). The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change to another doctor from the list may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

The insurance company providing coverage for this business  
under the Workers' Compensation Law is:

Cobb County School District  
Insurer Name

P.O. Box 1088, Marietta, Georgia 30061

770.426.3342

address

phone

#### PHYSICIANS' NAMES

<b>Concentra Medical Center (Urgent Care/Telehealth)</b>	220 N. Cobb PKWY #400 Marietta GA. 30062	770.424.7125
<b>Piedmont Urgent Care</b> West Cobb	2505 Dallas Hwy, Marietta. GA 30064	678.956.6230
<b>Piedmont Urgent Care</b> South Cobb	3999 Austell Rd #901 Austell, GA 30106	770.809.3032
<b>Piedmont Urgent Care</b> East Cobb	3120 Johnson Ferry Rd. Marietta GA 30062	770.835.4741
<b>Piedmont Urgent Care</b>	All Piedmont Urgent Care Locations Approved	678.660.5137
<b>Atlanta Neurological &amp; Spine Institute</b> Christopher Edwards, MD (Back, Orthopaedic Surgery)	1634 White Circle NW #101 Marietta, GA 30066	404.265.6701
<b>Peachtree Orthopaedics</b> Ezequiel Cassinelli, MD (Back, Orthopaedic Surgery)	1163 Johnson Ferry Rd #200 Marietta, GA 30068	404.355.0743
<b>Peachtree Orthopaedics</b> M Jonathan York, MD (Lower Extremity, Orthopaedic Surgery) Dwain Robertson, MD (Concussions)	3200 Downwood Circle NW #70 Atlanta, GA 30327	404.355.0743
<b>Peachtree Orthopaedics</b> Ashkan Lahiji, MD (Lower Extremity, Orthopaedic Surgery)	2001 Peachtree Rd NE #705 Atlanta, GA 30309	404.355.0743
<b>Pinnacle Orthopaedics</b> R Brandon Burris, MD (General, Orthopaedic Surgery) Nicolas S Bonnaig, MD (General, Orthopaedic Surgery)	300 Tower Rd #200 Marietta, GA 30060	770.427.5717
<b>Resurgens Orthopaedics</b> Glenn J Jonas, MD (Hand & Upper Extremity, Orthopaedic Surgery) Tapan K Daftari, MD (Back, Orthopaedic Surgery)	270 Chastain Rd Kennesaw, GA 30144	404.531.8484
<b>Resurgens Orthopaedics</b> Edward H Holliger, MD (Hand & Upper Extremity, Orthopaedic Surgery)	1285 Hembree Rd #200A Roswell, GA 30076	404.531.8484

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <https://sbwc.georgia.gov>

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to \$10,000.00 per violation (O.C.G.A. § 34-9-18 and § 34-9-19).

**JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA****DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO**

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

**Derechos de los Empleados**

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$800 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$800 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$533.33 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$533.33 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$800 por semana. Una esposa viuda sin niños se le pagara un máximo de \$320,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

**Responsabilidades de los Empleados**

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <https://www.sbcw.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-334-6865.

# PANEL DE DOCTORES

## AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

### LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, REPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagara una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un medico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un cambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

La compañía de seguro que provee cobertura para esta Empresa bajo la ley de Compensación de Trabajadores es:

Cobb County School District  
Asegurador Nombre

P.O. Box 1088, Marietta, Georgia 30061  
dirección

770.426.3342  
teléfono

#### DOCTORES NOMBRE

<b>Concentra Medical Center (Urgent Care/Telehealth)</b>	220 N. Cobb PKWY #400 Marietta GA. 30062	770.424.7125
<b>Piedmont Urgent Care</b> West Cobb	2505 Dallas Hwy, Marietta. GA 30064	678.956.6230
<b>Piedmont Urgent Care</b> South Cobb	3999 Austell Rd #901 Austell, GA 30106	770.809.3032
<b>Piedmont Urgent Care</b> East Cobb	3120 Johnson Ferry Rd. Marietta GA 30062	770.835.4741
<b>Piedmont Urgent Care</b>	All Piedmont Urgent Care Locations Approved	678.660.5137
<b>Atlanta Neurological &amp; Spine Institute</b> Christopher Edwards, MD (Back, Orthopaedic Surgery)	1634 White Circle NW #101 Marietta, GA 30066	404.265.6701
<b>Peachtree Orthopaedics</b> Ezequiel Cassinelli, MD (Back, Orthopaedic Surgery)	1163 Johnson Ferry Rd #200 Marietta, GA 30068	404.355.0743
<b>Peachtree Orthopaedics</b> M Jonathan York, MD (Lower Extremity, Orthopaedic Surgery) Dwain Robertson, MD (Concussions)	3200 Downwood Circle NW #70 Atlanta, GA 30327	404.355.0743
<b>Peachtree Orthopaedics</b> Ashkan Lahiji, MD (Lower Extremity, Orthopaedic Surgery)	2001 Peachtree Rd NE #705 Atlanta, GA 30309	404.355.0743
<b>Pinnacle Orthopaedics</b> R Brandon Burriss, MD (General, Orthopaedic Surgery) Nicolas S Bonnaig, MD (General, Orthopaedic Surgery)	300 Tower Rd #200 Marietta, GA 30060	770.427.5717
<b>Resurgens Orthopaedics</b> Glenn J Jonas, MD (Hand & Upper Extremity, Orthopaedic Surgery) Tapan K Daftari, MD (Back, Orthopaedic Surgery)	270 Chastain Rd Kennesaw, GA 30144	404.531.8484
<b>Resurgens Orthopaedics</b> Edward H Holliger, MD (Hand & Upper Extremity, Orthopaedic Surgery)	1285 Hembree Rd #200A Roswell, GA 30076	404.531.8484

SI USTED TIENE PREGUNTAS por favor comuníquese con THE STATE BOARD OF WORKERS' COMPENSATION AL telefono (404) 656-3818 o 1-800-533-0682 o VISITA la pagina WEB: <https://www.sbwg.georgia.gov>.

HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIDADES DE HASTA \$10,000.00 POR VIOLACIÓN (O.C.G.A. §34-9-18 y §34-9-19.)



# Anytime Access to Work Injury Care

At Concentra<sup>®</sup>, we believe that when you're hurt, you should be able to get care right away. **Concentra Telemed<sup>®</sup>** allows you to easily connect with a Concentra clinician for work injury care without visiting a medical facility.

## What can be treated via telemedicine?

- Minor strains (i.e., pulled muscles)
- Minor sprains
- Bruises/contusions
- Tendonitis/repetitive-use injuries
- Minor burns
- Minor cuts and scrapes
- Work-related rashes
- Bloodborne pathogen (BBP) exposures

## What you need:

- Smartphone, tablet, or computer with a webcam and microphone
- Photo ID
- Active email address
- Internet access
- Quiet area for privacy during visit



Scan to access  
Concentra Telemed

## How to Use Concentra Telemed

After informing your supervisor or safety personnel of your work-related condition and receiving authorization to obtain care via telemedicine, you are ready to start your telemedicine visit.

### Steps

#### 1. Access Concentra Telemed

Scan the QR code or open your web browser to [www.concentratelemed.com](http://www.concentratelemed.com). Then, click "Create Patient Account" and follow the prompts to create a new account.

#### 2. Visit Information

Enter the state you are currently in and some basic information. Then, select "First Visit Work Injury" for your initial center visit.

#### 3. Login

Confirm your information by checking the acknowledgment box and selecting "Confirm Visit." Then, wait to be connected with a care coordinator for patient check-in. Do not minimize or hide the video screen in the background.

#### 4. Check-in

A care coordinator connects with you to check you into the system and places you in a virtual waiting room until the clinician is ready.

#### 5. Visit

The clinician connects with you via video for evaluation, diagnosis, and treatment. Once done, the clinician reconnects you with the care coordinator.

#### 6. Checkout

The care coordinator completes patient checkout. You will receive visit details via secure email. Your employer can access pertinent visit details via Concentra HUB. Don't forget to tell us how we did!

## COBB COUNTY SCHOOL DISTRICT FIRST FILL PRESCRIPTION CARD

The First Fill Prescription Card enables employees to fill prescriptions written by a licensed prescriber for a work-related incident prior to the claim being reported or deemed compensable.

**INJURED WORKER:** Immediately following a work-related injury and receiving this sheet from your employer, please write your name and complete the unique Member ID by filling in the lines provided on the card below. Next to the COB00 enter the last 3 digits of your Social Security Number and then two-digit month and two-digit day of your injury and present this First Fill Prescription Card along with the valid prescription(s) to your local pharmacy.

If you have any questions regarding your work-related prescriptions, please call RxBridge toll free at 833-792-7434 for assistance. A Customer Service team member is available 24 hours a day, 7 days a week.



Inmediatamente después de una lesión relacionada con su trabajo y de recibir esta hoja de su empleador, escriba su nombre y complete el número de identificación de miembro, completando las líneas proporcionadas en la tarjeta a continuación. Junto al COB00 ingrese los últimos 3 dígitos de su Número de Seguro Social y luego el mes de su lesión con dos dígitos y el día de su lesión con dos dígitos y presente esta tarjeta de prescripciones First Fill junto con la (s) receta (s) válida (s) en su farmacia local.

Si tiene algún problema surtiendo medicina (s) relacionada (s) con su lesión ocupacional, por favor contáctenos al 1-833-792-7434 (1-833-Rxbridge) inmediatamente, para poder asistirle. Un miembro de nuestro equipo de servicio al cliente está disponible 24 horas al día, 7 días a la semana.

**PHARMACIST:** Using the billing information provided below, please fill the injured worker's injury-related prescription(s). **MAKE SURE YOU ENTER THE FULL MEMBER ID, INCLUDING THE LETTERS (EMPLOYER CODE).** Prescription card will be activated at the time prescription(s) are adjudicated and will allow a set quantity that is determined by the employer/insurance company. This card will remain active until midnight of the date of service. For Questions regarding transmission, rejections or if you encounter any problems processing prescription(s), please contact RxBridge toll free at 833-792-7434.

### FIRST FILL PRESCRIPTION CARD

Name: \_\_\_\_\_

Member ID: COB00 \_\_\_\_\_

**MUST SUBMIT ALL  
12 ALPHANUMERIC CHARACTERS**

Employer: COBB COUNTY SCHOOL DISTRICT

Group #: G7STD

RxBin: 984000

RxPCN: RXB

Issuer (80840): 9151014609

**ATTN: INJURED WORKER or PHARMACY**

**Complete the Member ID:** Please fill in the lines provided the COB00 with the last 3 digits of your Social Security Number and the two-digit month and two-digit day of your injury. (Example: COB001231219)

**Pharmacist:** When entering the Member ID, enter the full Member Id including the letters (employer code).

**ATENCION: EMPLEADO LESIONADO O PHARMACIA**

*Para completar su identificación de miembro: Complete las líneas provistas junto al COB00 con los últimos 3 dígitos de su Número de Seguro Social, el mes y el día de su lesión con dos dígitos.*

*(Ejemplo: COB001231219)*

**Farmacéutico:** al ingresar la identificación del miembro, ingrese el ID completo del miembro, incluyendo las letras (código de empleador).

**COBB COUNTY SCHOOL DISTRICT**

**Workman’s Compensation ~ Risk Management Mileage**

**Reimbursement Form Fax # 678-594-8580**

**EMPLOYEE NAME:** \_\_\_\_\_

<b>DATE</b>	<b>STARTING ADDRESS</b> (use complete address with city/zip)	<b>DESTINATION~ ADDRESS</b> (Ie: PT, Dr Appt ,etc.-use complete address with city/zip )	<b>MILES</b> <i>Roundtrip</i>

**One Year Deadline With Regard to Medical Expenses**

Section 4 of SB 233 also creates O.C.G.A. 34-9-200(c)(4), which provides for a one year deadline with regard to medical expenses. It states that, “Notwithstanding any other provisions of this subsection, if the employee or the provider of healthcare goods or services fails to submit its charges to the employer or its workers’ compensation insurer within one year of the date of service of the issuance of such goods or services, then the provider is deemed to have waived its right to collect such charges from the employer, its workers’ compensation insurer, and the employee.”