GADSDEN CITY SCHOOLS

Reporting an Employee On-the-Job Injury

In order to request reinstatement of days due to an on-the-job injury you must complete the following steps (documentation).

1. **Report Accident/Injury** ***(See Board Policy EGAA):*** Local Education Agency Injury Report (requires signature of injured person and their principal/supervisor). *LEAIR Form 1 (2/04)*

   The following documents are required to request reinstatement of sick days used due to an on-the-job injury:

2. Attending physician certification/documentation. *LEAPC Form 1 (2/04)*

3. Employee's request for days to be reinstated, verified by School Payroll Clerk: *"I further understand that I will not be allowed to request additional days of relief due to this same injury."*

4. Alabama State Board of Adjustment Notification Form: *"A claim that is not filed with the Board of Adjustment within one (1) year from the date of the accident will not be accepted."*

All four (4) documents must be submitted to the Superintendent's office to request reinstatement of sick days due to an on-the-job injury:

ON-THE-JOB INJURY

The Board adopts the following policy in regard to those employees of the Gadsden City School System who are accidentally injured while performing those duties of their assigned tasks:

1. The injury must have been caused by an unintentional action by the employee or fellow employee or by an act of the employee or fellow employee which does not have any contributing factor such as gross negligence or disobedience of instructions. As a matter of policy, any employee who is injured by a party or parties not employees of the Gadsden City Board of Education as a result of the employee's attempt to perform his/her assigned tasks or protect the property of the Gadsden City Board of Education or the lives and health and well-being of those entrusted to the Board will be fully protected under this policy.

2. Any on-the-job injury should be immediately reported to the employee's supervisor. The supervisor should make a report in writing to the superintendent's office of any injury that he or she feels has the potential of resulting in loss of work time.

3. The injury sustained under the terms of this policy must be of such severity or nature that the employee is rendered incapable of performing his/her regularly assigned duties.

4. Such disability as stated in number three (3) above must be documented by a written report from a duly licensed physician.

5. Any employee meeting the standards of this policy as stated above will be paid 100 percent of his/her salary for a period of ninety (90) working days, provided that the employee is totally unable to perform his/her duties during the ninety (90) days in question, without having such days of disability counted against the employee's sick leave or any other leave.

6. No leave may be granted until approved by the Board after recommendation of the superintendent.

7. Employees who are absent from work due to such job related injuries under conditions above described which result in partial or permanent disability shall be informed about their rights to proceed before the Alabama State Board of Adjustment.

8. Employees who request consideration under the "on-the-job injury policy" will be required to sign a statement that they have been notified of their option to appeal to the Alabama State Board of Adjustment.

ADOPTED: 7/2/96

LOCAL EDUCATION AGENCY
INJURY REPORT

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____ _____ _____	3. Date of Birth _____/_____/_____	4. Sex ___ M ___ F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status ___ Full Time ___ Part Time ___ Contract

9. Employing Agency	10. Agency Address (Number and Street) (City or Town) (State) (Zip)

11. Date of Injury	12. Time of Injury	13. Date Employer Notified
_____/_____/_____	____:_____ _____a.m. _____p.m.	_____/_____/_____

14. Is employee covered by medical insurance? ____Yes ____No If yes: ___Blue Cross/Blue Shield ___Other:	15. Name and address of attending physician

16. Name and address of medical facility where treated ____Hospitalized ____Outpatient ____Emergency Treatment	17. City or town where injury occurred	18. Location or place where injury occurred

19. Describe fully what happened to cause the injury or illness

20. Describe the injury or illness in detail and indicate the body part(s) affected

21. Were there any witnesses to the injury? ____Yes ____No (If "yes", give name, address, and telephone number)

22.

Signature of injured person	Print Name	Telephone Number (Daytime)	Date

23.

Signature of Supervisor (or other designated authority)	Print Name	Telephone Number (Daytime)	Date

LOCAL EDUCATION AGENCY
PHYSICIAN CERTIFICATION FORM

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Social Security Number _____ – ____ – _____	3. Date of Birth _____/____/_____	4. Sex ___ M ___ F
5. Home Address (Number and Street) (City or Town) (State) (Zip)	6. Telephone Number Home ( ) Work ( )	7. Job Title	8. Status ___ Full Time ___ Part Time ___ Contract
9. Employing Agency	10. Agency Address (Number and Street) (City or Town) (State) (Zip)		
11. Date of Injury ____/_____/_____	12. Is there a reasonable expectation that the employee will be able to return to work? ___ Yes ___ No	13. If "yes" on item 12, give the date or approximate date of return. _____/_____/_____	

14. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?

15. If "no" on item 12, give details for employee not being able to return to work.

16.

Signature of Attending Physician	Print Name	Telephone Number	Date

GADSDEN CITY SCHOOLS

Request for Reinstatement of Sick Leave

I understand that my request to have _____ sick leave day(s) reinstated to me by the Board of Education is the culmination of my on-the-job injury that occurred on _____. I further understand that I will not be allowed to request additional days of relief due to this same injury.

_____
(Employee's Name - Print)

_____
(Employee's Signature)

_____
(School)

_____
(Date)

_____
(# of days verified to be reinstated)

_____
(Signature – School Payroll Clerk)

GADSDEN CITY SCHOOLS

Alabama State Board of Adjustment Notification

I have been notified of my right to appeal to the Alabama State Board of Adjustment under the Gadsden Board of Education's policy for on-the-job injury.

There exists a Statute of Limitations for filing an injury claim before the Alabama State Board of Adjustment. The Board of Adjustment has established a clear and consistent date for filing a claim from which there will be no variation as stated in § 41-9-65 (a) *Code of Alabama*, 1975. A Claimant has one (1) year from the date of cause of action to file a claim. A claim that is not filed with the Board of Adjustment within one (1) year from the date of the accident will not be accepted.

_____

Employee's Signature

_____

Date