Occupational Health
Human Resources

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On-the-Job Injury & State Board of Adjustment Procedures

On-The-Job Injury

1. The employee submits a signed written account of the accident to the principal or supervisor within twenty-four (24) hours after the injury occurred. The written account shall be attested by the principal or supervisor and forwarded immediately to Amanda Barber, RN. If the injured employee is not able to notify the Occupational Health Nurse, another person reasonably knowledgeable about the employee's condition and circumstances leading to the injury may provide the required notification.

2. The injured employee submits written medical certification (attached forms) from the attending licensed physician within ten (10) days of the injury, stating that the employee was injured and was unable to work or cannot return to work due to a specified injury, if there is a reasonable expectation that the employee will return to work and, if so, the expected date of that return. The Board may require a second opinion from a Board specified physician, at its expense.

3. The Board may require an employee who is returning from an on-the-job injury leave to provide the Board with a healthcare provider's certification acceptable to the Superintendent in order to return to work.

State Board of Adjustment

FORMS CAN ALSO BE DOWNLOADED FROM THEIR WEBSITE:
finance.alabama.gov/board-of-adjustment

CLAIM MUST BE FILED WITHIN ONE YEAR OF INJURY,
NO EXCEPTIONS!

An employee who is injured on the job may file a request for unreimbursed medical expenses and costs with the State Board of Adjustment (forms attached). The Baldwin County Board of Education cannot pay these expenses.

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BALDWIN COUNTY BOARD OF EDUCATION
REPORT OF ABSENCE RESULTING FROM
ON-THE-JOB INJURY

TO BE COMPLETED BY EMPLOYEE

TO: _____ **SUPERVISOR/ADMINISTRATOR**

FROM: _____ **SCHOOL/SITE:** _____

I certify that this is a true and correct report of my absence from work resulting from an injury received during the performance of my official duties.

DATE(S) OF ABSENCE: _____

_____

TOTAL # OF DAYS: _____

EXPLANATION OF ACCIDENT: _____

_____

_____

_____

_____ _____
SIGNATURE OF EMPLOYEE DATE

TO BE COMPLETED BY SUPERVISING ADMINISTRATOR

TO: _____, **SUPERINTENDENT** **FROM:** _____

I certify that the above-named employee was, in fact, injured during the performance of his/her official duties and was absent from work on the date(s) indicated above.

REMARKS: _____

_____

_____

_____ _____
SIGNATURE OF SUPERVISOR/ADMINISTRATOR DATE

TO BE COMPLETED BY SUPERINTENDENT

THE ABOVE REQUEST FOR ON-THE-JOB INJURY HAS BEEN APPROVED OR DISAPPROVED AS INDICATED BELOW:

☐ APPROVED ☐ DISAPPROVED

REMARKS: _____

_____ _____
SIGNATURE OF SUPERINTENDENT DATE

LOCAL EDUCATION AGENCY
PHYSICIAN CERTIFICATION FORM

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Date of Birth ____/____/_____	3. Sex M_____ F _____
4. Home Address (Number and Street) (City or Town) (State) (Zip)	5. Telephone Number Home ( ) Work ( )	6. Status ___Full Time ___Part Time ___Contract

7. Employing Agency	8. Agency Address (Number and Street) (City or Town) (State) (Zip)	9. Job Title

10. Date of Injury ____/____/_____	11. Is there reasonable expectation that the employee will be able to return to work: ___ Yes ____ No	12. If "yes" on Item 11, give the date or approximate date of return ____/____/_____

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

14. If "no" on Item 11, give details for employee not being able to return to work.

16.

Signature of Attending Physician | Print Name | Telephone Number | Date

LOCAL EDUCATION AGENCY
INJURY REPORT

1. Name of Injured Employee (Please type or print) (Last) (First) (MI)	2. Date of Birth ____/____/_____	3. Sex M_____ F _____
4. Home Address (Number and Street) (City or Town) (State) (Zip)	5. Telephone Number Home ( ) Work ( )	7. Status ___Full Time ___Part Time ___Contract

7. Employing Agency	8. Agency Address (Number and Street) (City or Town) (State) (Zip)	9. Job Title

10. Date of Injury ____/____/_____	11. Time of Injury ___:_____ a.m. ___p.m.	12. Employer Notified _____/____/_____
13. Is employee covered by medical insurance? ___Yes ___No If yes: ___ Blue Cross/Blue Shield ___ Other: _____	14. Name and Address of attending physician	
15. Name and address of medical facility where treated ___ Hospitalized ___ Outpatient ___ Emergency Treatment	16. City or town where injury occurred	17. Location or place where injury occurred

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

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

20. Were there any witnesses to the injury? ___ Yes ___ No (If "yes," give name, address and telephone number)

21. _____
Signature of Injured Person Print Name Telephone Number Date

22. _____
Signature of Supervisor (or other designated authority) Print Name Telephone Number Date

INSTRUCTIONS FOR ALABAMA STATE BOARD OF ADJUSTMENT
CLAIM FOR ON THE JOB INJURY

www.bdadj.alabama.gov

NOTE: Claims must be presented to the Alabama State Board of Adjustment within one year after the date of the injury or within two years for claims for injury resulting in death. Each question must be answered. If all questions are not answered, the claim will not be accepted. Forms must printed in ink or typed. All supporting documentation must be submitted on 8 ½ x 11 paper front side only.
Please Note: The claims process may take several months to complete.

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Claim forms must be accompanied by all of the required documentation or your claim will be returned requesting further information. Any delays could cause the dismissal of your claim.

- **MAIL COMPLETED FORMS TO**:
  Alabama State Board of Adjustment
  600 Dexter Avenue, Suite E-302
  Montgomery, AL 36130-1435
- **FORMS MAY BE DELIVERED TO:**
  Alabama State Board of Adjustment
  State Capitol Building, Suite E-302
  Montgomery, Alabama
- Telephone Numbers: (334) 242-7175 Fax: (334) 242-2008

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1. Enter the name of the State Agency you are filing your claim against. (Example: Department of Transportation, Department of Education, etc.)

2. Enter your personal information. Enter your Name, Address, Telephone Number(s), E-mail Address, the last four digits of your Social Security Number or the last four digits of your FEIN if a business. Claims without the last four digits cannot be processed and will be returned to the Claimant.

3. If you have an attorney, enter your attorney's information. (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

4. Enter the facts of the claim:

   A. Enter the date the injury occurred.
   B. Enter the date notified by employer of your privilege to file a claim with the Board of Adjustment.
   C. Enter the location and address where the injury occurred. (Example: Lunchroom at City Elementary, City, Alabama 36000)
   D. A statement of facts describing the injury and the events surrounding the injury. Documentation must accompany the claim for proof of the injury. Provide an official accident or incident report showing the date of the injury. The report must be signed by a supervisor or some other official. Any other evidence to prove that the incident upon which the claim is based took place must be attached. (Example: Dated and signed witness statements.)

5. If this was an on-the-job injury, check yes. If no, use Personal Injury Form. This form can be found on the Board of Adjustment web site shown at the top of this page.

6. Employer Information:

   A. Enter the name, address and telephone number of your employer.
   B. Enter your job title at the time of the injury.
   C. Enter your supervisor's name at the time of the injury.
   D. If you are still employed with employer listed in 6A check the "Yes" box.
   E. If you are no longer employed with employer listed in 6A, enter your last date of employment.

7. Medical Expenses: Enter all out-of-pocket medical expenses incurred as a result of the injury. List each health care provider, including pharmacy, and the amount charged by each. You must provide evidence (itemized bills) to show what treatment was provided, when it was provided, and the charge, as well as evidence of insurance filing and payments (insurance company summary sheets). Board of Adjustment will not make awards for expenses paid by private insurance. If claimant is not covered by insurance, this should be clearly stated.
   A. Total of Medical Expenses Claimed
8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you.
   A. Total Payments Made to You from All Insurance Companies
9. Medical Disability: If you are claiming medical disability, you MUST complete this section.

   A. If you are claiming damages for permanent disability, check "Yes"; otherwise, check "No.
   B. If you have claimed compensation for permanent disability from any source, such as Social Security Disability, Workman's Compensation, etc., check "Yes"; otherwise, check "No".
   C. Enter the amount you are seeking for permanent or total disability.
   D. Describe the permanent disability. Evidence (usually a letter, statement, or report from physician) that claimant has reached maximum medical improvement "MMI" and is left with a disability stated in percentage of physical impairment to the whole body or part of body is involved (arm, leg, finger, etc.). Include calculations as to the amount of disability being claimed.

10. Wages: If you are claiming lost wages and/or compensation for leave used, list each separately. You must provide each of the following types of documents as evidence:
    - A signed statement from a doctor or other healthcare provider that claimant was unable to work because of the accident or injury stated.
    - Verification from the employer of the time lost from work or the leave deducted and verification from the employer of the claimant's rate of pay at the time of the accident or injury.
    - A leave balance statement from the employer showing leave accrual balances and years of service.

    A. Enter the amount of wages you lost due to the injury. Circle whether the amount you have entered is for hours, days or weeks. (Example: $25 for 2 hours)
    B. Enter the amount of leave used. (Example: 16 hours for 2 days)
    C. Enter your rate of pay at the time of your injury. Check the box indicating whether the amount is per hour, day, or week. (Example $12.50 per hour)
    D. Enter the total of wages lost due to the injury.
11. Enter any miscellaneous expenses associated with the personal injury, such as damages to automobile, eyeglasses, mileage, etc. Note: If claiming mileage, use the Mileage Log which is available on the Board of Adjustment web site and include mileage documentation such as MapQuest or Google maps for each destination. Mileage rates are available on the Comptroller's web site, http://comptroller.alabama.gov/.

    11 A. Provide the total amount of miscellaneous expenses claimed.

12. Enter the GRAND TOTAL amount you are claiming for all items described in Items 7.A., 9.C., 10D. and 11.
13. Sign the claim form in the presence of a Notary Public, print your name and have the notary complete the verification section.

ALABAMA STATE BOARD OF ADJUSTMENT
CLAIM FOR PERSONAL INJURY - ON THE JOB

See Page 1-2 of this form for instructions. Each number on the form corresponds with numbers on instruction sheets. Read all instructions carefully to ensure your claim is not returned for additional supporting documentation. See INSTRUCTIONS for mailing or hand delivering this form to the Board of Adjustment (Page 1).	**DO NOT WRITE IN THIS SPACE. FOR BOARD OF ADJUSTMENT USE ONLY.** **Claim No.:**_____

1. Name of the Department or Agency of the State of Alabama against which you are making this claim:

   _____

2. Claimant's Information:

   Name: _____

   Street Address or P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Home Telephone No.: _____ Office Telephone No.: _____

   Cellular Telephone No.: _____Fax No.: _____

   Claimant's Last Four Digits of Social Security No. or last four digits of Business FEIN:

   SSN: XXX-XX-_____ FEIN: XX-XXX _____

3. Claimant's Attorney: (NOTE: If an attorney is listed, all correspondence will be with the attorney only.)

   Attorney Name: _____

   Street Address of P.O. Box: _____

   City, State, Zip Code: _____

   E-mail Address: _____

   Office Telephone No.: _____Fax No.: _____

4. Facts of Claim:

   A. Date of Injury: _____

   B. Date notified by employer of your privilege to file a claim with Board of Adjustment:_____

   C. Location/Address of Injury: _____

   D. Statement of Facts (Describe the injury and the events surrounding the injury): _____

   _____

   _____

   _____

5. Was this an on-the-job injury? ☐ Yes ☐ No

6. Employer Information (If on-the-job injury):

   A. Name, Address & Telephone Number of Employer: _____

   _____

   _____

   B. Job Title at the Time of the Injury: _____

   C. Name of Supervisor at the Time of the Injury: _____

   D. Are you still employed with employer listed in 6.A.? ☐ Yes ☐ No

   E. If no, what was the date of your last day of employment? _____

7. Medical Expenses (List each health care provider, including pharmacy, and the amount charged by each): Include additional sheets if necessary:

Provider	Amount of Out-of-Pocket Expense

   A. Total of Medical Expenses Claimed: $_____

8. If you had medical insurance at the time of the injury, name all insurance companies and state how much each paid directly to you:

Name of Insurance Company (Includes Medicare, Medicaid)	Amount Paid To You

   A. Total Payments Made to You from All Insurance Companies: $ _____

9. Medical Disability:

   A. Are you claiming damages for permanent disability? ☐ Yes ☐ No

   B. Have you claimed compensation for permanent disability for this injury from any other source, such as Social Security Disability, Workers Compensation, etc.? ☐ Yes ☐ No

   C. What is the amount you are seeking for permanent or total disability? _____

   D. Describe the permanent disability: _____

   _____

   _____

10. Wages: If you are claiming lost wages and/or compensation for leave used, list each separately. You must provide each of the following types of documents as evidence:

    - A signed statement from a doctor or other health care provider that claimant was unable to work because of the accident or injury stated.
    - Verification from the employer of the time lost from work or the leave deducted and verification from the employer of the claimant's rate of pay at the time of the accident or injury.
    - A leave balance statement from the employer showing leave accrual balances and years of service.

    A. Amount of lost wages: _____ for _____ hours/days/weeks

    B. Amount of leave used: _____ for _____ hours/days/weeks

    C. Rate of Pay at time of Injury: _____ per ☐ Hour ☐ Day ☐ Week

    D. Total Wages Claimed: $_____

11. Miscellaneous Expenses: (List other expenses you are claiming and the amount for each such as damages to auto, eyeglasses, mileage, etc.) If claiming mileage, use the Mileage Log which is listed on the web site, www.bdadj.alabama.gov, as Alabama State Board of Adjustment Mileage Log.

Item	Amount of Expense

A. Total Amount of Miscellaneous Expenses Claimed: $_____

Claimant's Name_____

12. What is the **GRAND TOTAL** amount you are claiming for all items listed in 7.A., 9.C., 10.D. & 11.A.

    $_____

13. Signature of Claimant/Authorized Representative: _____

    Please Print Name: _____

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VERIFICATION

STATE OF _____

COUNTY OF _____

Before me, a Notary Public in and for said state and county, personally appeared the person whose name is signed above who being made known to me and being duly sworn to give true testimony, affirmed that all of the above stated facts are true and correct.
Sworn and subscribed before me this _____ day of _____, 20 _____

Signature of Notary Public _____

AFFIX SEAL Printed Name _____