Howard County Public School System

Circular No.14
Series 2023–2024
October 11, 2023

Division of Human Resources and Professional Development

2023-2024 Procedures for Workers Compensation
and Employee Incident Reports

To: All Staff

From: David Larner
Chief Human Resources and Professional Development Officer

Attached please find a copy of the updated procedures for reporting a work-related injury/illness. Also, please find sample copies of the Workers' Compensation Commission First Report of Injury (Form IA-1) and Employee Incident Report, referred to in the procedures.

Please read the procedures thoroughly and, in particular, pay careful attention to what you must do when an employee assigned to your school/area is injured or assaulted. Please inform your staff of the procedures for reporting incidents and obtaining medical care. Failure to follow these procedures may impact the workers' compensation benefits received. The forms must be completed and forwarded to Human Resources within 24 hours of the injury.

Additional forms are available from the Workers' Compensation Specialist upon request and are also available on the Staff Hub under: Services, Employee Resources, Workers' Compensation.

If you have any questions, please contact the Office of Workers' Compensation at 410-313-7494.

DKL/lab

Attachment

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042

Workers' Compensation

Program and Procedures

Last Revised: 10/06/23

TABLE OF CONTENTS

HCPSS WORKERS' COMPENSATION PROGRAM

Workers' Compensation is a program that provides benefits for an employee who sustains a compensable work-related injury or illness while performing assigned job duties in the course of employment. All work-related injuries/illnesses must be reported; whether medical attention is needed or not. Compensable work-related injuries/illnesses of employees are subject to the Maryland Workers' Compensation laws and regulations.

The Howard County Public School System (HCPSS) Workers' Compensation benefits and procedures are as follows:

1. Appropriate medical attention (first aid and/or professional medical care) will be provided immediately to an employee sustaining a work-related injury/illness. Professional medical care is provided through the following procedures:

    a. **Call 911 immediately for a life-threatening injury/illness**. If the employee is not admitted to the hospital, the **employee** may be referred to an industrial/urgent care clinic for a return-to-work evaluation within 24 hours of treatment from the hospital.

    b. **Non-emergency injury/illness**. The employee may report to Concentra Medical Center (Columbia, Jessup and other location), Patient First (Columbia, Catonsville, Laurel and other locations) or other industrial/urgent care center for work evaluation and/or treatment. If opting for treatment with either Concentra or Patient First, a Treatment Authorization form is to be taken by the employee when going for the initial visit. This form is to be provided (and completed) by the employee's site of employment (school or office). Employees may also select their own treatment center – provided that treater agrees to accept Workers' Compensation and are not a specialist (which requires a referral and authorization prior to treating).

    c. If it is a non-emergency injury/illness, and the employee requires professional medical care after normal hours of operation, Concentra Medical Centers has a 24 hour facility where treatment can be obtained, or the employee may receive treatment from a different industrial/urgent care medical provider. The **employee** is **required** to provide a copy of a work status report which outlines their workability (or any work restrictions) at the start of the next business day following the evaluation.

2. All incidents must be reported by the employee to a supervisor immediately after the event. Any employee or individual aware of the incident may report the incident, if the injured/ill employee is unable to do so.

a. Failure to notify a supervisor of an incident may subject the employee to disciplinary action and, if applicable, the 90-day full salary benefit may be forfeited.

b. An Employee Incident/Injury Report will be completed for all incidents as soon as possible - ***even those that do not require medical attention***. This form serves as notification of the incident, should medical attention be required at a later date, as well as a tool for tracking potential incident trends.

1. The employee completes each question on Section I (front page), signs, dates the form, and returns it to the Principal/Supervisor/Lead Person.

2. Section II is completed, signed, and dated by the principal/supervisor/lead person. All questions must be answered.

3. Submit a complete and signed copy of the Report to the Office of Workers' Compensation within 24 hours of the injury/illness (email or fax, 410-313-7349). If it is a serious injury/illness (either 911 or an off-work status is involved), call the Workers' Compensation Specialist to provide details before sending the form. Then forward the original copy to the Office of Workers' Compensation.

3. The Workers' Compensation First Report of Injury must be completed for all injuries that require medical attention and/or lost time from work.

a. **The principal/facility manager completes this form. The injured/ill employee does not complete or sign this form.**

1. The principal or facility manager must sign and date.

2. Thorough responses must be provided regarding questions about the injury/illness.

3. Submit a complete and signed copy of the Report to the Office of Workers' Compensation within 24 hours of the injury/illness (email or fax, 410-313-7349). If it is a serious injury/illness (either 911 or an off-work status is involved), call the Workers' Compensation Specialist to provide details before sending the form. Then forward the original copy.

4. SISCO (Self-Insured Services Company) is the Workers' Compensation Third Party Claims Administrator for the Howard County Public School System.

a. SISCO will investigate and determine if the claim meets the criteria under Maryland state law for a compensable Workers' Compensation claim.

5. The injured/ill **employee** must **immediately notify** his/her Principal / Supervisor / Lead person if he/she is placed off from work or if there are temporary work

restrictions assigned and a determination needs to be made about possible duty modifications.

a. Following every appointment (or at the beginning of the next scheduled workday), the employee must submit a copy of their work status to his/her Principal / Supervisor / Lead Person for review of the work status and restrictions

b. Work status reports will be reviewed and job tasks may be modified as per the work restrictions. Work status reports are required by the Workers' Compensation claim administrator (SISCO), the Workers' Compensation Specialist, and by the employee's school/department in order to evaluate whether modified duty assignments can be determined.

c. The Workers' Compensation Specialist is to be notified by the Principal / Facility Manager / Lead Person when they are unable to provide temporary modified work. The Workers' Compensation Specialist will work with the employee's Manager in evaluating alternate and temporary assignments for the employee based upon the work restrictions, employee's skills, and length of disability.

d. All employees of HCPSS are subject to modified duty assignments. Modified duty assignments are temporary short-term work assignments. Assignments are contingent upon medical status and needs of the school system.

e. Employees are required to provide information concerning work status and medical treatment as requested by the Workers' Compensation Specialist.

f. When an employee returns to work from a leave of absence, he/she must provide the supervisor and Workers' Compensation Specialist medical certification which clearly outlines their workability. The certification must include the date of return to work and whether there are any work restrictions. **Note: The doctor must indicate the type of work restrictions ("modified" or "light duty" is not sufficient), as well as the duration the work restrictions are to be in place.**

g. An employee receiving treatment must make the attempt to schedule appointments before or after work hours, or as close to that time as possible.

6. **All time lost from work due to a work-related compensable injury/illness must be supported by medical certification**. During the period of disability, salary compensation will be as follows:

a. No salary will be paid to the employee under Workers' Compensation until SISCO has determined that the claim is compensable.

b. A disability slip is required by the Workers' Compensation Specialist, and by the employee's school/department for payment of lost time from work.

c. Any compensation for lost time due to a work-related injury must be supported by an off-duty status by Concentra Medical Centers, Patient First or other industrial/urgent care clinic. In the absence of any required disability certification, time lost from work will be charged to accrued leave, or if none, leave without pay. Compensable lost time will be either subject to the HCPSS 90-day benefit or paid at the rate equal to or greater than specified by Maryland Workers' Compensation regulations.

d. Failure to substantiate time away from work by proper medical certification may result in the forfeiture of benefits for full pay under the HCPSS 90-day benefit. It is not a denial of a Workers' Compensation claim or any compensation due under the Workers' Compensation regulations.

NOTE: Employees covered by negotiated agreements, meet and confer agreements and Administrative Management are eligible for salary benefits under the 90-day benefit. Temporary and non-benefited employees are not eligible for this benefit.

7. If the employee is unable to return to work due to a compensable work-related injury/illness, HCPSS will provide compensation at the employee's regular rate of pay for a period not to exceed 90 workdays without loss of annual, sick, or personal leave or fringe benefits for the employee. The availability of the 90 days expires one year from the date of the injury/illness. However, if the leave starts within the one-year period, the 90-workday benefit will remain in effect even if the length of the disability extends beyond the anniversary of the date of injury/illness.

    a. Subject to employee eligibility, a period of incapacity of more than three days will be considered a serious health condition, as defined by the Family and Medical Leave Act (FMLA). Days will be counted under an employee's annual FMLA entitlement (12 weeks/60 working days) and will run concurrently with a Workers' Compensation leave.

    b. During the 90-day period, an employee will be paid at their regular rate of pay.

    c. Employees will be paid for time away from work to attend an initial visit to the clinic to treat for a work-related injury (and supporting documentation is provided), and unless a claim is denied, for follow-up visits, therapy appointments or to attend an independent medical evaluation at the request of SISCO or HCPSS.

    d. Failure to use provided safety equipment or improper use of equipment and materials may result in loss of eligibility for full salary benefits under the 90-day benefit.

    e. A claim resulting from an employee's willful misconduct will be subject to denial under the Maryland Workers' Compensation law.

8. After the 90-day period expires and the employee has not returned to work, the employee has the option to use available accrued leave (first sick, then other personal leave) to make up the difference between Workers' Compensation benefits and his/her full regular salary in order to continue to receive full salary payments. If the employee elects not to use accrued leave, or if none is available, the employee will remain on an approved leave of absence without pay and will continue to receive any Workers' Compensation benefits to which he/she is entitled.

    a. Any salary payments made by SISCO to the employee, not applicable to the 90-day period, will belong to the employee.

    b. Subject to FMLA eligibility, an employee may return to the same or substantially equivalent position and location within 12 weeks (60 working days) of the work-related injury/illness. If the employee is not able to return to work within the 12-week time (FMLA) period (including the 90-day period), the employee may be assigned to a same or equivalent position when a vacancy becomes available for which the employee is qualified. The employee may be placed at the grade and step held at the time of injury, or if placed in an equivalent position an appropriate grade and step for that position. Pay increments occurring during an employee's time away from work are subject to approval by the Human Resources Office.

    c. After an absence of six months (including the 90-day period), the employee's continued leave and reasonable accommodations will be evaluated on a periodic basis. During this time, the employee may use any available accrued leave.

    d. The approved leave of absence will not affect any benefits that may be due under the Workers' Compensation law.

9. The Department of Human Resources will be notified when the 90-day period expires or of other circumstances which may require consideration for the continued leave of absence.

10. If SISCO has determined that the injury/illness is a non-compensable claim, then:

    a. If the employee is not able to return to work, he/she may use accrued leave, if available, and apply for a leave of absence for the duration of the recovery period. Leave is subject to FMLA.

    b. If leave is not available, the employee must apply for an unpaid leave of absence for the duration of the recovery period. Leave is subject to FMLA.

    c. Reassignment will be determined by the Department of Human Resources.

    d. All time lost from work will be charged to the employee's accrued leave, and if none, the employee will be placed in a no-pay status.

e. SISCO will notify the employee when a claim has been denied, and will inform the employee of their options of filing an appeal, if desired.

11. If the employee is physically injured in the scope of his/her employment as the result of an assault and is absent due to physical disability that results from the assault, the employee will be kept on full pay status instead of sick leave during the period of absence. In this case, the following will apply:

    a. Assault is defined as an intentional, unprovoked attack intended to do harm to another that results in a physical injury.
    b. The employee must immediately notify their supervisor of the incident and injury.
    c. The employee is required to complete the Employee Incident Report of Injury/Illness and completely describe the incident and why it is considered an assault.
    d. HCPSS will file the claim to report the incident/injury.
    e. Procedures for the 90-day full salary benefit are followed, to include certification from the medical provider of the employee's disability.
    f. If the employee's disability extends beyond the 90-day full salary benefit, then assault leave may apply. Assault leave is paid leave provided in accordance with §6-111 of the Education Article of Maryland Statute.
    g. The employee will submit medical documentation from a licensed physician to SISCO for determination of any Workers' Compensation temporary total benefits that may be due.
    h. If SISCO determines that temporary total benefits are due, then the employee will receive Assault leave in lieu of temporary total benefits with no sick leave charged.
    i. HCPSS may require a medical examination conducted by a physician selected and paid for by HCPSS.
    j. Only permanent employees are eligible for Assault Leave.
    k. Assault leave will end when the employee returns to work, temporary total benefits end, and/or if the employee retires.
    l. HCPSS may require the employee apply for disability retirement.

Contact the Office of Workers' Compensation at 410-313-7494 with any questions.

PROCEDURES FOR MEDICAL ATTENTION

WORKERS' COMPENSATION

EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that requires emergency assistance (911 or use of an ambulance) shall:

- Call 911 immediately for life-threatening injury/illness.
- Contact next of kin, spouse, or emergency contact person.
- Report all 911 calls to the Office of Workers' Compensation (410-313-7494).
- Unless admitted to the hospital, the employee must report to an Urgent Care (i.e.: Concentra Medical Center, Patient First) or other medical clinic on the next business day for work evaluation and/or treatment.
- Follow procedures under Non-Emergency Injury/Illness after visit.

NON-EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that does not require emergency medical care (911) shall:

- Obtain an Employer's Authorization for Examination or Treatment from his/her principal/supervisor/lead person.
- Employee must report for work evaluation and/or treatment at an industrial/urgent care location (i.e.: Concentra Medical Center, Patient First) or other medical clinic.
- Each employee will receive an Activity Status Report or work status slip following their evaluation. Employee shall return either to the principal or designated staff, supervisor, or lead person for a review of the work status and accommodations based on any work restrictions
- Notify the Office of Workers' Compensation if unable to modify the job tasks at the employee's regular work site, or if the employee is placed in an off-work status.
- The Workers' Compensation Specialist will work with the Employee's supervisor/direct report in evaluating alternate and temporary assignments for the employee based upon the work restrictions, employee's skills, and length of disability.
- All employees may be assigned to modified duty assignments.

The Activity Status Report from Concentra Medical Center (or note from any other industrial/urgent care center or medical clinic) must substantiate time away from work due to a work-related injury/illness. A doctor's note is given to the employee at the conclusion of each visit to Concentra Medical Center (or the Employee is obligated to ask for a work status note following an evaluation at an industrial/urgent care center or medical clinic). This note must be given to the Workers' Compensation Specialist and/or employee's principal/supervisor/lead person for review of the work status and restrictions upon return from the evaluation, for review of any necessary job modifications to accommodate work restrictions.

Concentra locations in and near Howard County

6656 Dobbin Road
Columbia, MD 21045
410-381-1330 Fax 410-381-5585

7377 Washington Blvd.
Jessup, MD 21075
410-379-3051 Fax 410-379-3074

Both locations are open 8:00 am – 5:00 pm Monday through Friday.

Patient First locations in and near Howard County

5900 Cedar Lane
Columbia, MD 21044
443-718-4067 Fax 443-718-4068

6333 Baltimore National Pike
Catonsville, MD 21228
443-514-1361 Fax 443-514-1362

3357 E. Corridor Marketplace
Laurel, MD 20724
301-497-1820 Fax 301-497-5489

All locations are open 8:00 AM – 10:00 PM every day

Work-Related Injury/Illness Reporting Checklist

- Unless the injury is serious, please complete the following prior to sending employees for treatment, and forward to the Office of Workers' Compensation **within 24 hours of injury or notification of injury**:

  - **Workers' Compensation – First Report of Injury or Illness**: Supervisor / Principal / Lead Person completes. Please provide as much detail as possible regarding the incident/injury (i.e.: time of occurrence, type of injury/illness, specific activity employee was engaged in and exactly how the injury/illness occurred)

  - **Employee Incident/Injury Report**: injured worker completes Section I; Supervisor / Principal / Lead Person completes Section II. Please ensure the cause of the accident and corrective action in response to the incident/injury are both identified

- You may encourage employees to seek treatment at Concentra Medical Centers, Patient First, or any industrial/urgent care clinic which specialize in work-related injuries; however employees have the option to treat at the medical facility of their choice – as long as they confirm the treater agrees to accept Workers' Compensation injuries and they are not a specialist (which requires a referral and prior authorization)

- Employees are responsible for providing a copy of their work status to the Workers' Compensation Specialist and/or Supervisor / Facilities Manager immediately after their appointment. A doctor's note must be provided following each doctor visit in order to remain updated on any changes in work status

- If an employee is taken off work, or the temporary work restrictions cannot be accommodated, contact the Office of Workers' Compensation immediately to discuss temporary modified duty or alternative accommodations

- All employees who have been off work due to a work-related injury must submit written authorization to return to work from their doctor ***prior to or upon*** returning to work. The release must indicate the effective date of their return and outline any restrictions which could now be accommodated, or they have been released to regular duty

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042

SIC CODE

EMPLOYER FEIN: 52-60000968

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #: (410) 313-6600

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

Self-Insured

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☒ SELF INSURANCE

CLAIMS ADMINISTRATION (NAME, ADDRESS & PHONE NO)

SISCO
RCM&D Self-Insured Services, Co, Inc.
555 Fairmount Avenue
Baltimore, MD 21286-5497
(410) 339-7263

CARRIER FEIN

POLICY/SELF-INSURED NUMBER: 1508

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ M MALE
☐ F FEMALE
☐ U UNKNOWN

MARITAL STATUS

☐ U UNMARRIED (SINGLE/DIVORCED)
☐ M MARRIED
☐ S SEPARATE
☐ K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

TELEPHONE (INCLUDE AREA CODE)

OF DEPENDENTS

WAGE

RATE

PER: DAY MONTH WEEK OTHER:

DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGAURDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

☐ 0 NO MEDICAL TREATMENT
☐ 1 MINOR: BY EMPLOYER
☐ 2 MINOR: CLINIC/HOSP
☐ 3 EMERGENCY CARE
☐ 4 HOSPITALIZED – 24 HOURS
☐ 5 FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

OTHER

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE (Princ/Supvr's Signature)

PHONE NUMBER

Exhibit A

Workers' Compensation Office
Justin_Waters@hcpss.org 410-313-7494
Fax 410-680-3427

EMPLOYEE INCIDENT/INJURY REPORT

SECTION I: Completed by the injured employee (*prior to seeking medical treatment*)

- Please provide responses to all questions in Section I
- Ask your Supervisor/Principal for assistance if you do not understand any questions
- After completing, return the form to your Supervisor/Principal

Employee Name: _____ Employee Number: E_____

Job Title: _____ Home/Cell Phone: _____

School/Facility: _____

Incident Date: _____/_____/_____ Incident Time: _____ ❍ AM ❍ PM

Incident location (hallway, classroom, etc.): _____

Describe in detail what happened. _____
_____
_____

Does the incident fall under the definition of "assault" (an unprovoked attack with the intention of causing harm to another that results in a physical injury)? ❍ Yes ❍ No

Names of person(s) who witnessed the incident: _____

When did you report the incident? ___/____/___ Who did you report it to? _____

Do you require medical treatment? ❍ Yes ❍ No

If "Yes", which medical clinic? ❍ Concentra ❍ Howard County General Hospital ❍ Other

If "Other", please provide name, address and phone number of treatment location: _____
_____
_____

Injured Part of Body and Type of Injury? (i.e. right ankle sprain) _____

Please provide a copy of your work status immediately following any treatment for a work-related injury, so your Supervisor can be notified of any changes in your workability.

Signature of Employee _____ Date _____

Section II: Completed and signed by the Supervisor and Principal

- Please provide responses to all questions in Section II; keep a copy for your records
- Scan/email the completed form & First Report of Injury form to Justin Waters ***within 24 hours*** of the injury/illness; serious injuries/911 calls must be reported immediately

Who informed you of the incident? _____
How were you informed? _____ When? _____
List any additional information that you may have concerning how the injury occurred.
_____

Please indicate accident cause(s) which contributed to this incident:

❍ **Housekeeping** – unsafe storage, clutter, items on floor, congested work area, untidy work area
❍ **Physical safeguards** – unguarded machinery, warning signs not posted, inadequate protective equipment, defective equipment
❍ **Task methods** – disregard of instructions, operating without authority, unsafe loading/unloading, unsafe posture/position, poor lighting, unsafe methods/procedures/processes, poor ventilation, safeguards not provided, protective equipment not provided, use of equipment/materials unsafely
❍ **Supervision** – inadequate direct supervision, failure to enforce rules, toleration of unsafe practices, protective equipment not used
❍ **Other** – combative student, horseplay, substance use, improper clothing/footwear, weather, *implementation of an approved Safety Care restraint

*If you checked "Implementation of an approved Safety Care restraint" please answer these additional questions:

1. Is the Employee certified in Safety Care? ❍ **Yes** ❍ **No**

2. Did the injury occur prior to the implementation of restraint? ❍ **Yes** ❍ **No**

3. Did the injury occur during the time Employee was implementing a restraint? ❍ **Yes** ❍ **No**

Please list the corrective actions which will be taken as a result of this incident? _____
_____

Could use of protective equipment (blocking pads, scrub boots, eyewear, etc.) have prevented this injury? ❍ Yes ❍ No

If the injury was defined as "assault", what was the recourse taken as a result?
_____

If this was the result of a human bite/scratch, refer employee to health assistant/cluster nurse for notification requirements.

Has employee returned to work? ❍ Yes ❍ No If yes, when? _____

If there are any temporary work restrictions, are you able to accommodate? ❍ Yes ❍ No

If no, contact the Workers' Compensation Office immediately for job placement or other accommodations of the injured employee.

Signature of Supervisor _____ Date _____

Signature of Principal/Facility Manager _____ Date_____

Concentra™

(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: Howard County Public Schools Date of Birth: _____

Street Address: 10910 Clarksville Pike, Ellicott City, MD Location Number: N/A

Temporary Staffing Agency: N/A

Work Related

❑ Injury ❑ Illness

Date of Injury _____

Substance Abuse Testing★ (check all that apply)

❑ Regulated drug screen ❑ Breath alcohol

❑ Collection only ❑ Hair collect

❑ Non-regulated drug screen ❑ Rapid drug screen

❑ Other _____

Type of Substance Abuse Testing

❑ Preplacement ❑ Reasonable cause

❑ Post-accident ❑ Random

❑ Follow-up

Physical Examination

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

DOT Physical Examination

❑ Preplacement ❑ Recertification

Special Examination

❑ Asbestos ❑ Respirator ❑ Audiogram

❑ Human Performance Evaluation★

❑ HAZMAT ❑ Medical Surveillance

❑ Other _____

Billing (check if applicable)

❑ Employee to pay charges

Special instructions/comments: _____

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: Justin Waters Title: Workers' Compensation Specialist

Please print

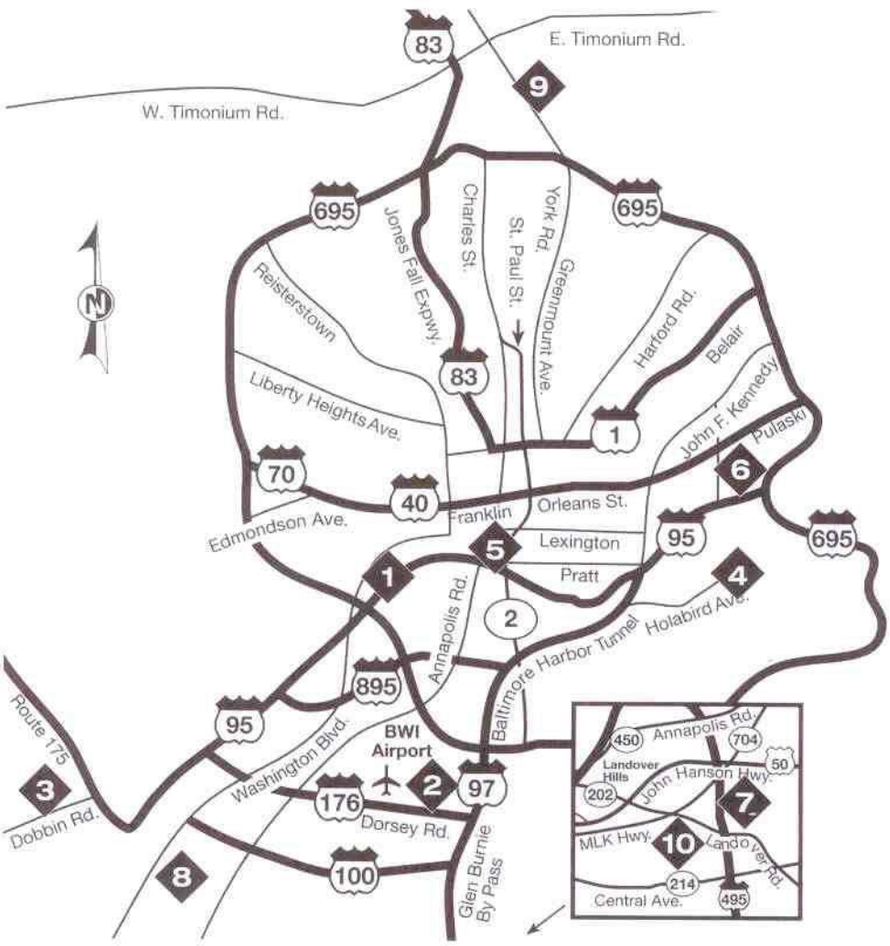
Phone: (410) 313-7494 _____

Date

Concentra now offers urgent care services for non-work related illness and injury. We accept many insurance plans.

(Copies of this form are available at www.concentra.com)

Exhibit C



1 Arbutus
AFTER HOURS FACILITY
1419 Knecht Ave.
Baltimore, MD 21227
Mon: 7 am - Sat: 12 pm
410.247.9595
FAX: 410.247.7553

2 BWI Airport
811 Cromwell Park Dr.
Suite 104-105
Glen Burnie, MD 21061
Mon - Fri: 7:30 am - 5 pm
410.553.0110
FAX: 410.553.0197

3 Columbia
6656 Dobbin Rd.
Columbia, MD 21045
Mon - Fri: 8 am - 5 pm
410.381.1330
FAX: 410.381.5585

4 Dundalk
Holabird Business Park
1833 Portal St.
Baltimore, MD 21224
Mon - Fri: 8 am - 5 pm
410.633.3600
FAX: 410.633.3604

5 Downtown
100 S. Charles St., Ste. 150
Baltimore, MD 21201
Mon - Fri: 8 am - 5 pm
410.752.3010
FAX: 410.539.7023

6 Rosedale
8101 Pulaski Hwy., Ste. H
Baltimore, MD 21237
Mon - Fri: 7 am - 7 pm
Sat: 7 am - 12 pm
410.687.6462
FAX: 410.687.2261

7 Lanham
4451 G Parliament Pl.
Lanham, MD 20706
Mon - Fri: 7 am - 8 pm
Sat: 7 am - 12 pm
301.459.9113
FAX: 301.459.1214

8 Jessup
7377 Washington Blvd.
Suite 101
Elkridge, MD 21075
Mon - Fri: 8 am - 5 pm
410.379.3051
FAX: 410.379.3074

9 Timonium
Yorkridge Center
1840 York Rd., Ste. E
Timonium, MD 21093
Mon - Fri: 8 am - 5 pm
410.252.4015
FAX: 410.252.7410

10 Landover
8700 Central Ave.
Landover, MD 20785
Mon - Fri: 8 am - 5 pm
301.499.4655
FAX: 301.499.0902

C2110AUTH

Exhibit C

Authorization for Examination or Treatment

Patient First
www.patientfirst.com

Please check off services needed for your employee's visit.

Use of this form requires an established account with an Industrial Client (I.C.) Number. Forms presented without an I.C. # will not be accepted. If you do not have an active I.C. account, please contact us by calling (866) 253-9139.

Patient Information:

Company Name: Howard County Public Schools - Ellicott City, MD	**Date of Birth:**	**I.C. #:** 2550
Patient Name:	**Last 4 Digits of SS#:**	

Work Related:

☐ Injury ☐ Illness **Date of Injury** _____

Physical Examination:

DOT:	NON-DOT:
☐ Pre-employment ☐ Recertification	☐ Pre-employment

Substance Abuse Testing:

Urine Drug Screens:

☐ DOT (5-panel)

☐ Non-DOT (10-panel)

☐ Instant Drug Screen (5-panel)

Alcohol Screens:

☐ Breath test (EBT)

☐ Blood test

Special Procedures:

☐ PPD Placement

☐ Chest X-ray

☐ Hepatitis B

☐ Flu vaccination

☐ Other _____

Special Instruction / Comments

Please fax the work status note to Justin Waters at: (410) 680-3427

Authorization:

Phone: 410-313-7494	**Date:**
Printed Name: Justin Waters, Workers' Compensation Specialist	**Signature:**

Form#: 629 Rev. 10/30/19

Exhibit C