SHAWNEE MISSION
SCHOOL DISTRICT

Dear Staff Member:

In conjunction with the priority we place on workplace safety and personal wellness, this packet is designed to assist you in obtaining appropriate treatment for workplace injury. Please review this information carefully and follow each step as prescribed. Your assistance is greatly appreciated and will result in a more complete and effective process for all involved.

Please see the enclosed page, PROCEDURES FOR TREATING WORK INJURIES, for additional information on the Priority One Health Center, as well as other, treatment specific, clinic options. It is important to note that no provider will treat your injury without the proper completed and signed authorization form. These forms are available at each work site and must be signed by your supervisor, nurse or building administrator. **Please be sure to take the signed authorization form to the clinic in order to receive treatment.**

All injuries require you to complete an on-line incident report no later than TWO days after your injury. Your school nurse or secretary will need to complete this report. You will also need to sign the yellow form attached to this sheet and return it to Carol Loera at the Center for Academic Achievement (8200 W. 71st Street). It is important to understand that invoices related to your medical treatment cannot be paid without an incident report and this completed and signed form.

After your injury has been treated, you will be given a report that indicates any physical/work restrictions you may have, or a report that releases you to return to work without restrictions. The doctor's report serves as communication between the clinic and your employer. Therefore, **a copy of the doctor's report should be returned to your supervisor to make them aware of any restrictions. Another copy of this information must be submitted to the workers compensation office at** Center for Academic Achievement **(CAA).** The doctor's report also provides critical information for the payroll department should you need to be absent from work for an extended period of time.

Your injury will be reported to the State of Kansas. State law requires that you be adequately informed of your rights; therefore, you will receive communications from the Department of Labor, Division of Workers Compensation. Feel free to contact our office at (913) 993-6417 if you have questions or concerns.

On occasion, employees receive invoices at their homes for medical care required for their work injuries. Please understand that billing offices for medical providers do not always know who received the medical care. All they have is a name and no way of knowing if medical care had been provided for the employee, a spouse, or a child. Billing offices mail only **one** invoice each month, and they assume employees know where to forward these invoices for payment. **Please forward any received invoices to the workers compensation office at the CAA. If we do not receive invoices, the medical provider could begin collection procedures.**

Again, please take time to read the information in this packet, particularly WHAT YOU SHOULD KNOW ABOUT WORKERS COMPENSATION. If you have any questions, please contact me directly at (913) 993-6417. The district is contracted with a third party administrative services firm, Thomas McGee, to provide additional support. If you would like to discuss your claim with our case manager, please contact Sammye Strickler at 816-843-4415. We are all available to assist you in any way possible.

Sincerely,

Carol Loera
Human Resources

WHAT YOU SHOULD KNOW ABOUT WORKERS COMPENSATION

It is every staff member's responsibility to perform their responsibilities in a manner that prevents accidents and/or injuries to themselves and fellow employees. If you are aware of unsafe conditions, please immediately refer this information to your supervisor. Understanding accidents do occur, all staff must be aware of school district policy and Kansas statutes concerning workers' compensation. **All injuries should be immediately communicated to a supervisor.**

Kansas statutes control workers compensation coverage, and benefits are subject to legislative changes. **The state statutes require employees to report their work injuries within 20 days.** An injury is covered according to the rules in force during the fiscal year in which the injury occurred. Therefore, an individual who is injured on the job on June 30 might receive a different weekly workers compensation benefit for lost wages than an individual injured on July 1. During this school year, July 1, 2019 through June 30, 2020 an injured employee is entitled to a weekly amount of 66-2/3% of his/her average wage up to a maximum of $687.00 to offset lost wages. If the injury results in permanent disability, the Kansas Compensation law provides for additional benefits. An injured employee is entitled to all medical services reasonably necessary to cure and relieve the employee from the effects of the injury. Under Kansas Statute 44-515, the Shawnee Mission School District has the right to select the doctor who will treat the injury.

The Shawnee Mission School District is self-insured for workers compensation and has contracted a third party administrator, Thomas McGee (816-843-4415) to manage claims and pay medical bills. Funds used to pay workers compensation benefits come from tax revenue.

It is very important to get completed and signed paperwork to the Center for Academic Achievement (CAA) as immediately as possible. Thomas McGee cannot pay medical expenses for any claims until your paperwork is filed. Once a claim is filed, an adjuster from Thomas McGee will be assigned to your case and personal contact will be made with you to assure that you will receive the most appropriate care. These adjusters are very knowledgeable in workers compensation benefits and medical management, and they are interested in helping you get back to 100%. Please be sure to communicate any questions or concerns with your adjuster. If you experience challenges related to your claim and feel uncomfortable discussing this with your adjuster, please feel free to contact Carol Loera at the CAA (913-993-6278), or contact a representative at the Claims Advisory/Ombudsman of the Division of Workers Compensation, at 1-800-332-0353 (toll-free).

Additional information may be found in district booklets published annually for our employees. Policies for certified personnel are published in the Negotiated Agreement between the board of education and NEA, and classified policies are printed in the Personnel Policies for Classified Employees handbook.

Check with your administrator or supervisor and be familiar with where workers compensation forms are kept in your building so you will be prepared if an injury does occur.

PROCEDURES FOR TREATING WORK INJURIES

If you or one of your co-workers is injured on the job, NOTIFY YOUR SUPERVISOR IMMEDIATELY.

- Administer first aid. If the injury is life threatening, call 911 and send the injured person to the nearest hospital. (Ambulances will only transport injured employees to a local hospital, not to one of the clinics.)
- If the injury is not life threatening, but an ambulance is needed, please have the injured employee transported to Shawnee Mission Medical Center.
- The building administrator, nurse or department supervisor should provide the injured employee with the packet of information about how to treat work injuries, as well as sign the appropriate medical authorization form. **Clinics will not treat an employee without authorization.** It's always a good idea to notify the workers compensation office at CAA (913) 993-6417 that you are sending an employee for treatment.

Shawnee Mission School District work comp walk-in clinics:

Priority One (Marathon)
8200 W 71st St
Overland Park, KS 66204
913-549-9970

Located at the Center for Academic Achievement: in the north west corner of the building.
Clinic Hours:
Monday, Wednesday, Friday 7:00am to 4:00pm
Tuesday and Thursday 9:00am to 6:00pm

CONCENTRA - (Employer Health Services)
7:30 am to 5:00 pm - Monday-Friday

14809 West 95th Street
Lenexa, KS 66215
Phone: 913-894-6664
Fax: 913-894-6891

CORPORATE CARE
8:00 am to 5:00 pm - Monday-Friday
CENTRA CARE – URGENT CARE- (several locations)
8am-8pm M-F; 8am – 5pm WEEKENDS

9040 Quivira Rd
Lenexa, KS 66215
Phone: 913-492-9675
Fax: 913-894-9591

U.S HEALTHWORKS
8:00 am to 5:00 pm - Monday-Friday
Physician on call nights and weekends.

15319 W. 95th
Lenexa, KS 66219
Phone: 913-495-9905
Fax: 913-495-9945

KU MEDWEST
7:30 am to 9 pm - Monday-Friday
8:00 am to 4:00 pm - Saturdays and Sundays

Occupational Health Clinic, Suite D
7405 Renner Road
Shawnee, KS 66217
Phone: 913-588-2200
Fax: 913-588-8423

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.

Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to $500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE. De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros $500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

Thomas McGee — **(816) 843-4415**

Employer's Insurance Carrier (Compañía Aseguradora del Empleador) — Telephone (Teléfono de la Aseguradora)

120 W. 12th St., Suite 1000 Kansas City, MO 64105-1938

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: KDOL.wc@ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 11-16)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER APRIL 25, 2013 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 20 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 10 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 ⅔ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

   Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

   As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at http://www.dol.ks.gov/WorkComp/edinews.aspx.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5, 102(a)
EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company Thomas McGee

Address 120 W. 12th St. Suite 1000, Kansas City, MO 64105-1938

Contact Person Sammye Strickler

Phone (816) 843-4415

Email sstrickler@thomasmcgee.com

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.

   Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.

   Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.

2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5, 102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía Thomas McGee

Dirección 120 W. 12th Street, Suite 1000, KC, MO 64105-1938

Persona de Contacto Sammye Strickler

Teléfono (816) 843-4415

Correo electrónico sstrickler@thomasmcgee.com

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 11-16)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE ABRIL 25, 2013 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) **NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE**: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 20 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, 20 días a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 10 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) **SIGA LAS INSTUCCIONES DE SU EMPLEADOR** para conseguir ayuda médica y siga las instrucciones del doctor.

(3) **BENEFICIOS MÉDICOS:** El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) **BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio.** Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

AdventHealth Centra Care | Corporate Care

AUTHORIZATION TO TREAT FORM

Clinic Locations:

☐ **CorporateCare Lenexa** 9040 Quivira Road Lenexa, KS 66215 Phone: 913-492-9675 Fax: 913-438-8726 M-F, 8am – 5pm	☐ **Centra Care Overland Park** 9099 W 135th Street Overland Park, KS 66221 Phone: 913-549-4242 Fax: 913-602-8911 M-F, 8am - 8pm; Weekends, 8am - 5pm	☐ **Centra Care Olathe** 14744 W 119th Street Olathe, KS 66062 Phone: 913-839-1759 Fax: 913-839-9588 M-F, 8am - 8pm; Weekends, 8am - 5pm	☐ **Centra Care Shawnee** 11245 Shawnee Mission Parkway Shawnee, KS 66203 Phone: 913-268-4455 Fax: 913-268-4493 M-F, 8am - 8pm; Weekends, 8am - 5pm

Employee Name:_____ **Date:**_____ **Time Authorized:** _____
Please print clearly

Employer Name: _____

Employer Address:_____

Date/Time Employee will come in (if known): _____

Authorized By: _____ _____ **Phone:** _____
Print Name Signature

SERVICES REQUESTED:

SUBSTANCE ABUSE TESTING: **DOT Regulated Employers Must Identify Agency Under Which Specimen Will Be Collected**
☐ **FMCSA** ☐ **FAA** ☐ **FTA** ☐ **USCG** ☐ **PHMSA** ☐ **FRA**

Reason for Testing:

Category of Substance Abuse Test: ☐ **NON-DOT (Non-Federal)** ☐ **DOT (Federal)**

☐ New Hire	☐ Random	☐ Reasonable Suspicion
☐ Post-Injury (NON-DOT)	☐ Post-Accident/Vehicle	☐ Return-to-Duty (Applies to Federal Only)
☐ Follow-up	☐ Other (Specify) _____	☐ Return-to-Work

Type of Substance Abuse Test to be Performed:

Drug Screen: ☐ Urine Drug Test 5-Panel ☐ Urine Drug Test 10-Panel Expanded
☐ Rapid/Instant Test 5-Panel ☐ Rapid/Instant Test 10-Panel
☐ Collection Only ☐ CISAP ☐ Hair Test
☐ Saliva/Oral Fluid Drug Test ☐ MCA (Pipefitters/Plumbers) ☐ Other: _____

Alcohol: ☐ Breath Alcohol

INJURY CARE: **REMINDER: Check above if post-injury substance abuse testing is required per your company policy.**

Date of Injury:_____ Time of Injury:_____ Part of Body Injured:_____ Claim #:_____

Description of Injury: _____

OTHER SERVICES: **Appointments are appreciated, but not required.**

Exams: ☐ New Hire ☐ DOT (New or Re-Cert) ☐ Respirator Exam ☐ Return-To-Work ☐ Fitness-For-Duty

Post-Offer Testing: ☐ Essential Functions Test ☐ PCP Physical Capacity Profile® Test
☐ EFA (Electrodiagnostic Functional Assessment) ☐ Respirator Fit Test (Qualitative or Quantitative)

Other:

☐ Vaccinations: ☐ Hepatitis B ☐ Other (specify)_____ ☐ Audiogram ☐ Hearing Conservation

☐ TB Test ☐ Other: _____

Marathon Health
For life.

AUTHORIZATION FOR MEDICAL TREATMENT

Shawnee Mission School District

Patient Name: _____ Date of Birth: _____

Date of Work Related Injury or Illness: _____

Nature of Injury: _____

_____

_____

Authorized By: _____ Date: _____

Priority One Health Center

Monday	7am-4pm
Tuesday	9am-6pm
Wednesday	7am-4pm
Thursday	9am-6pm
Friday	7am-4pm

TREATMENT AUTHORIZATION

AUT

U.S. HealthWorks MEDICAL GROUP
A Dignity Health Member

We are authorizing the below listed U.S. HealthWorks(s) to provide treatment to our employees. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify USHW of the denial and will be responsible for payment for all services rendered and any medically-necessary items dispensed.

U.S. HEALTHWORKS MEDICAL GROUP LOCATED AT:

ADDRESS: _____

PHONE: _____ FAX: _____

EMPLOYER

EMPLOYER NAME: _____ EMPLOYER# (if applicable): _____

EMPLOYER ADDRESS: _____ PRIMARY CONTACT NAME: _____

PHONE: _____ AFTER HRS / CELL PHONE: _____

FAX: _____ EMAIL: _____

EMPLOYEE DETAILS

PATIENT NAME: _____ DATE: _____ TIME: _____ AM / PM

DEPARTMENT: _____ POSITION: _____

DOES EMPLOYEE WORK FOR A TEMP/LEASING COMPANY? ○ YES ○ NO NAME OF TEMP AGENCY: _____

AUTHORIZED BY: NAME (print): _____ PHONE: _____

TITLE: _____ AFTER HRS / CELL PHONE: _____

SIGNATURE: _____ ( ) VERBAL AUTHORIZATION

INSURANCE

INSURANCE COMPANY NAME _____

CLAIMS ADDRESS: _____

PHONE: _____ EFFECTIVE DATE: _____

POLICY #: _____ EXPIRATION DATE: _____

SERVICES

○ INJURY: DATE OF INJURY: _____ LAST WORKED: _____

INJURED BODY PART: _____ CLAIM #: _____

○ RETURN-TO-WORK EVALUATION: _____

○ PHYSICAL EXAM TYPE: _____ PROTOCOL #: _____

○ DRUG/ALCOHOL TEST - specify type and reason/purpose below: PROTOCOL #: _____

TYPE:

- ☐ DOT DRUG TEST
- ☐ DOT BREATH ALCOHOL TEST
  Agency (required): _____
- ☐ NON-DOT DRUG TEST
- ☐ NON-DOT BREATH ALCOHOL TEST
- ☐ INSTANT DRUG TEST

REASON/PURPOSE:

- ☐ PRE-EMPLOYMENT
- ☐ RANDOM
- ☐ REASONABLE SUSPICION
- ☐ POST-ACCIDENT
- ☐ RETURN TO DUTY
- ☐ FOLLOW UP
- ☐ POST-INJURY

Perform test before: Date: _____ Time: _____ AM / PM

* PICTURE ID REQUIRED FOR DRUG TEST

Concentra®

Improve the health of America's workforce, one patient at a time.

Employer Services
Patient Information

About You

Reason for Today's Visit

☐ Injury Care ☐ Physical exam ☐ DOT (CDL) Certification ☐ Drug Screen ☐ Other: _____

Social Security # or Military DBN: _____ Date of birth (MM/DD/YYYY): _____

Last name: _____ First name: _____ M.I.: ____

Address: _____ Apt. #: _____ City: _____ ST: _____ ZIP: _____

Home phone: _____ Work phone: _____

Cell phone: _____ ☐ Male ☐ Female ☐ Single ☐ Married

Email address: _____ Concentra may send a detailed email: ☐ Yes ☐ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted.

About Your Employer

Employer Requesting Services

Company name: _____ Location/store number: _____

Contact name: _____ Contact phone: _____

Address: _____ Ste. #: _____ City: _____ ST: _____ ZIP: _____

Is your employment arranged through a temporary hire agency? ☐ No ☐ Yes

Name of agency: _____ Agency phone: _____

Consent

The information provided is correct to the best of my knowledge. I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

✍ Signature: _____ Date: _____

I give permission to Concentra to perform the following services that the physicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnostic (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine information statements ("VIS" or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases.

✍ Signature: _____ Date: _____

Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it. If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy office at 800-819-5571 or privacyoffice@Concentra.com.

Name: (please print) _____ Date Notice Received: _____

✍ Signature: _____ Date: _____

Occupational Health
7405 Renner Rd
Shawnee, KS 66217
PHONE: (913) 588-2200
FAX: (913) 588-8423

USE URGENT CARE ENTRANCE
Mondays – Fridays 7:30 a.m. – 9:00 p.m.
Saturdays and Sundays 10:00 a.m. – 2:00 p.m.

MEDICAL TREATMENT AUTHORIZATION FORM

☐ Work Related Injury ☐ Initial Visit ☐ Follow-up Visit

Employee's Name _____
Last First Middle Initial

Employer's Name Shawnee Mission School District _____ 66204;

Name of your building _____

Your building telephone number _____

Date of Injury _____

Nature of Injury _____

_____

Authorized by: _____ _____
Name / Title Date

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Shawnee, KS 66217
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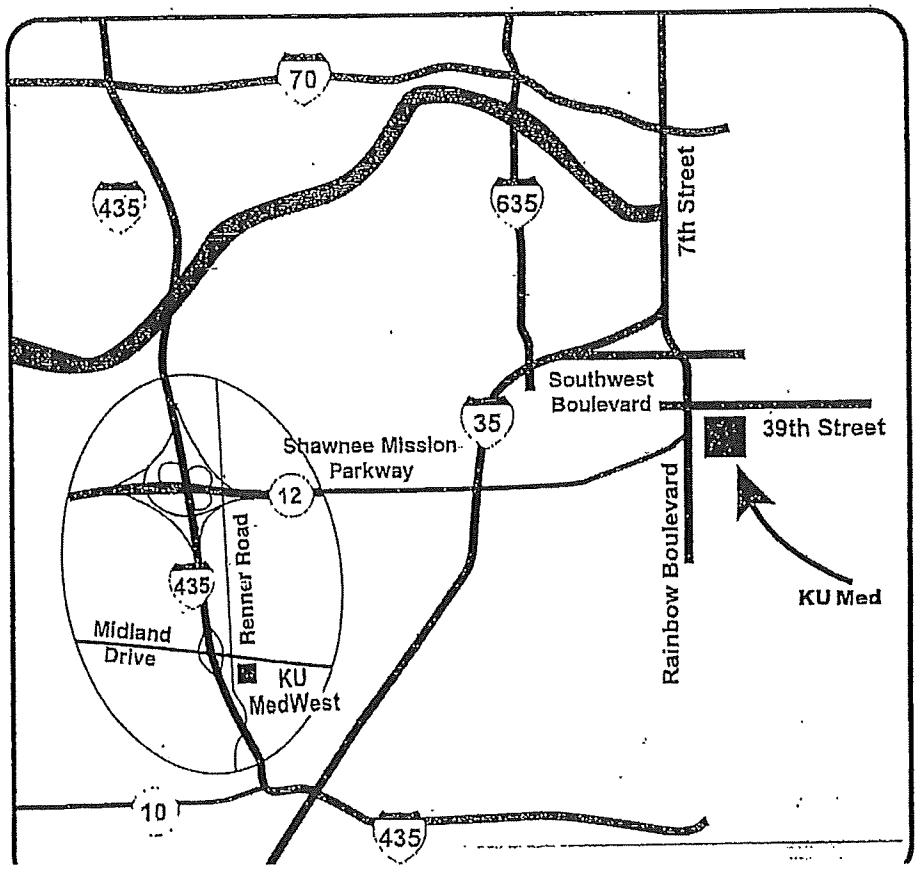

USE URGENT CARE ENTRANCE

SHAWNEE MISSION SCHOOL DISTRICT

MEDICAL AUTHORIZATION BY INJURED EMPLOYEE

I, the undersigned, do here by authorize and request you to permit inspection of, or to furnish copies to Thomas McGee, L.C., 120 W. 12th Street, Suite 1000, PO Box 419013, Kansas City, MO 64141-6013, my and all medical or hospital records, information and X-rays, of your facility, pertaining to all aspects of my treatment and care, rendered on my behalf or at the request of another health care provider. A photocopy or facsimile of the authorization shall be considered as effective as the original.

_____
Social Security Number

_____
Date of Birth

_____
Signature

_____
Today's Date