Workers' Compensation--FAQs:

- All incidents must have a report on file within 10 days even if no medical attention is provided at the time.
- All employees must receive medical care from JRMC's Urgent Care Center or Emergency Department.
- Workers' Comp. visits to PCPs will not be covered unless referred.
- All medical care must be approved by AR Municipal League prior to treatment.
- Employees must have/use sick & vacation in order to receive a paycheck from the City.
- Employees must be off from work for 7 consecutive days before Workers' Comp. issues a check for time lost.
- Employees are still responsible for insurance payments even while off work. An invoice will be sent from HR.
- Do NOT file work-related injuries on your health insurance! Tell the provider to bill AR Municipal League only.
- Please provide necessary documentation to HR and supervisor at all times.
- Contact HR for any billing issues.
- Light duty is available in most departments. If an employee is placed on light duty, then the employee must return to work or WC benefits will be denied.
- Employees must follow physician orders to receive full WC benefits.
- All claims are entitled to ONE "change of physician request."
- All employees will be mailed a copy of their Form N for their records.

CITY OF PINE BLUFF
WORKERS' COMPENSATION AUTHORIZATION FORM

This communication certifies that the individual below is an employee with the City of Pine Bluff and needs to receive medical attention for a work-related injury. I authorize the medical provider to offer treatment to the person below.

Patient Name: _____ **DOB:** ___/___/___

Date of Incident: ___/___/___ Type of Injury: _____

_____ Emergency _____ Non-Emergency

Form Completed By:

_____ _____

Dept. Designee's Signature Date

_____ _____

Printed Name Position Title

WC Carrier: AR Municipal League WCT
P.O. Box 38 | 301 West 2nd | N. Little Rock, AR 72115
(501) 374-3484

Fax to: Tina Horton, JRMC Urgent Care Center @ 870.541.8662

Forward all bills to: City of Pine Bluff, 200 East 8th Avenue, Room 104, Pine Bluff, AR 71601
For questions or more information, please contact Ralynn/Vickie @ 870.730.2038

WORKERS' COMPENSATION—FIRST REPORT OF INJURY/ILLNESS

Employer	**Carrier**
City of Pine Bluff Pine Bluff, AR 71601	Municipal League Workers' Compensation Trust P.O. Box 37 North Little Rock, AR 72115 501-374-3484

EMPLOYEE/WAGE

SSN - -	NAME (LAST, FIRST, MI)	DOB (mm/dd/yyyy)	GENDER ☐ Male ☐ Female

ADDRESS (street, apt., city, state, zip)	MARITAL STATUS	NO. OF DEPENDENTS
	☐ Unmarried/Single/Divorced ☐ Married ☐ Separated ☐ Unknown	

PERSONAL PHONE ( ) -	WORK PHONE ( ) -

EMPLOYMENT STATUS (circle one) FT PT Volunteer Elected Off.	DATE OF HIRE (mm/dd/yyyy)	STATE OF HIRE Arkansas
OCCUPATION TITLE	SUPERVISOR	PAY RATE $ per HR/YR
# DAYS WORKED/WEEK	FULL PAY FOR DAY CONTINUE? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO	

OCCURRENCE/TREATMENT

DATE OF INJURY (mm/dd/yyyy)	TIME EMPLOYEE BEGAN WORK	AM / PM	TIME OF OCCURRENCE	AM / PM
DATE NOTIFIED EMPLOYER	LAST WORK DATE		DATE DISABILITY BEGAN	

CONTACT NAME & PHONE NUMBER

TYPE OF INJURY/ILLNESS	PART/SIDE OF BODY AFFECTED	DID INJURY/ILLNESS OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO

DEPARTMENT OR LOCATION WHERE ACCIDENT/ILLNESS EXPOSURE OCCURRED

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

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

WORK PROCESS EMPLOYEE ENGAGED IN WHEN ACCIDENT/ILLNESS EXPOSURE OCCURRED

DESCRIBE FULLY HOW THE ACCIDENT/ILLNESS OCCURRED.

DATE RETURNED TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

HEALTH CARE PROVIDER (SELECT ONE)		**INITIAL TREATMENT (SELECT ONE)**	
JEFFERSON REGIONAL 1600 WEST 40TH AVENUE PINE BLUFF, AR 71601 (870) 541-7100	URGENT CARE 4201 S. MULBERRY STREET PINE BLUFF, AR 71601 (870) 541-8660	0	NO MEDICAL TREATMENT
		1	MINOR: BY EMPLOYER
		2	MINOR: BY CLINIC/HOSPITAL
		3	EMERGENCY CARE
		4	HOSPITALIZED > 24 HOURS
		5	FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

DEPARTMENT DESIGNEE NAME & TITLE	CONTACT NUMBER	DATE SIGNED

MUNICIPAL LEAGUE
WORKERS' COMPENSATION TRUST
P.O. BOX 37
NORTH LITTLE ROCK, ARKANSAS 72115
PHONE (501) 374-3484

SUPPLEMENT TO THE EMPLOYER'S REPORT OF INJURY

NAME OF EMPLOYER_____

NAME OF EMPLOYEE_____

DATE OF INJURY_____ DATE OF REPORT_____

*To help identify the causes of employee injury, please **select the one** answer in each of the following six (6) sections that best describes the events at the time of the accident.*

TASK BEING PERFORMED AT TIME OF ACCIDENT *(CHECK ONLY ONE)*

- ☐ 101 Housekeeping
- ☐ 102 Maintenance/Repair Of Vehicle
  Maintenance/Repair Of Roadway
- ☐ 103 Maintenance/Repair, Other
- ☐ 104 Moving to/from Location on Foot
- ☐ 105 Operating Machinery
- ☐ 106 Materials Handling Operations
- ☐ 107 Office Tasks
- ☐ 108 Operating/Riding in/on Motor Vehicle
- ☐ 109 Operating/Using Hand/Power Tools
- ☐ 110 Unauthorized Task
- ☐ 111 Multiple Tasks or Unknown
- ☐ 112 Other

(FOLLOWING ARE FOR PUBLIC SAFETY ONLY)

- ☐ 113 Controlling Suspect/Prisoner/Patient
- ☐ 114 Controlling/Capturing an Animal
- ☐ 115 Fighting a Fire
- ☐ 116 Haz-Mat Incident
- ☐ 117 Non-Emergency Operations at an Incident
- ☐ 118 Pursuing a Suspect
- ☐ 119 Responding to an Emergency (In Vehicle)
- ☐ 120 Returning from an Emergency (In Vehicle)

INCIDENT CLASSIFICATION *(CHECK ONLY ONE)*

- ☐ 201 Assault
- ☐ 202 Bite (Animal, Human, Insect)
- ☐ 203 Caught In, Under or Between
- ☐ 204 Contact with Electric Current
- ☐ 205 Contact with Foreign Matter (Dirt in Eye, etc.)
- ☐ 206 Contact with Sharp Object
- ☐ 207 Contact with Temperature Extremes (Burns, etc.)
- ☐ 208 Exposure to Environmental Cold/Heat
- ☐ 209 Exposure to Fire Products
- ☐ 210 Exposure to Hazardous Substances/Chemicals
- ☐ 211 Exposure to Infectious Substances
- ☐ 212 Fall on Same Level
- ☐ 213 Fall to Different Level
- ☐ 214 Gunshot
- ☐ 215 Physical Overexertion/Overextension
- ☐ 216 Psychological Trauma
- ☐ 217 Repetition of Pressure/Motion (Noise, CTS)
- ☐ 218 Slip/Trip without Fall
- ☐ 219 Struck Against
- ☐ 220 Struck By
- ☐ 221 Vehicle Accident
- ☐ 222 Other

BODILY ACTIVITY AT TIME OF INCIDENT *(CHECK ONE)*

- ☐ 301 Bending
- ☐ 302 Climbing
- ☐ 303 Crawling
- ☐ 304 Driving
- ☐ 305 Jumping/Landing
- ☐ 306 Kneeling
- ☐ 307 Lifting
- ☐ 308 Lying Down
- ☐ 309 Mounting/Dismounting Vehicle or Equipment
- ☐ 310 Pulling
- ☐ 311 Pushing
- ☐ 312 Reaching/Stretching
- ☐ 313 Riding
- ☐ 314 Running
- ☐ 315 Sitting
- ☐ 316 Standing
- ☐ 317 Twisting
- ☐ 318 Walking
- ☐ 319 Multiple Actions
- ☐ 320 Unknown

NATURE OF INJURY/ILLNESS *(CHECK ONE)*

- ☐ 401 Abrasion
- ☐ 402 Amputation
- ☐ 403 Blunt/Penetrating Trauma
- ☐ 404 Bruise/Contusion
- ☐ 405 Burn (Chemical)
- ☐ 406 Burn (Electrical)
- ☐ 407 Burn (Heat)
- ☐ 408 Cancer
- ☐ 409 Concussion/Unconscious
- ☐ 410 Conjunctivitis
- ☐ 411 Contagious/Infectious Disease
- ☐ 412 Coronary/Artery Condition
- ☐ 413 Crush
- ☐ 414 Cumulative Trauma Disorder
- ☐ 415 Cut/Scratch/Puncture
- ☐ 416 Dislocation
- ☐ 417 Electric Shock
- ☐ 418 Fatality
- ☐ 419 Foreign Substance (Eye)
- ☐ 420 Fracture
- ☐ 421 Heat Stroke/Stress
- ☐ 422 Heart Attack
- ☐ 423 Hernia/Rupture
- ☐ 424 Hypertension
- ☐ 425 Impaired Sensory Perception
- ☐ 426 Inflammation
- ☐ 427 Lung Disease
- ☐ 428 Muscle Spasm
- ☐ 429 Poisoning, Systematic
- ☐ 430 Psychological Disorder
- ☐ 431 Respiratory Illness
- ☐ 432 Separation/Avulsion
- ☐ 433 Sprain/Strain
- ☐ 434 Suffocation/Asphyxiation
- ☐ 435 Other

BODY PART MOST AFFECTED

HEAD/NECK
- ☐ 501 Ear/Hearing
- ☐ 502 Eye/Sight
- ☐ 503 Face
- ☐ 504 Jaw
- ☐ 505 Mouth/Teeth
- ☐ 506 Nose
- ☐ 507 Psychiatric
- ☐ 508 Scalp/Skull
- ☐ 509 Neck/Throat

TRUNK
- ☐ 510 Abdomen
- ☐ 511 Back
- ☐ 512 Chest
- ☐ 513 Groin/Genitalia
- ☐ 514 Heart
- ☐ 515 Hip/Buttock
- ☐ 516 Shoulder

BODY SYSTEMS
- ☐ 527 Cardiovascular System
- ☐ 528 Digestive System
- ☐ 529 Excretory System (Kidneys/Bladder/Intestines)
- ☐ 530 Musculoskeletal System (Bones/Joints/Tendons/Muscles)
- ☐ 531 Nervous System
- ☐ 532 Respiratory System
- ☐ 533 Skin
- ☐ 534 Entire Body (Some Illnesses/Exposures)

UPPER EXTREMITIES
- ☐ 517 Arm (Upper or Lower)
- ☐ 518 Elbow
- ☐ 519 Finger/Thumb
- ☐ 520 Hand
- ☐ 521 Wrist

LOWER EXTREMITIES
- ☐ 522 Ankle
- ☐ 523 Foot
- ☐ 524 Knee
- ☐ 525 Leg
- ☐ 526 Toe

CONTRIBUTING CAUSES: HAZARDOUS CONDITIONS/UNSAFE ACTS *(SELECT ONLY ONE)*

- ☐ 601 Actions of Others
- ☐ 602 Alteration of Safety Devices
- ☐ 603 Assembly or Design Flaws
- ☐ 604 Attention to Footings/Surroundings
- ☐ 605 Atmosphere/Ventilation
- ☐ 606 Congestion/Housekeeping
- ☐ 607 Dress/Apparel
- ☐ 608 Excavation/Trench
- ☐ 609 Fire Hazard
- ☐ 610 Guard/Safety Device
- ☐ 611 Horseplay
- ☐ 612 Illumination/Glare
- ☐ 613 Lack of Instruction/Warning
- ☐ 614 Lack of Labeling/Warning
- ☐ 615 Ladders/Improper Use
- ☐ 616 Loading
- ☐ 617 Maintenance
- ☐ 618 Method or Procedure
- ☐ 619 Natural Environment/Weather
- ☐ 620 Noise
- ☐ 621 Related to the Use of Personal Protective Equipment
- ☐ 622 Related to Proper Body Positioning
- ☐ 623 Sharp/Protruding (Not Intentionally Sharp Objects)
- ☐ 624 Slippery (Not Walking/Working Surface)
- ☐ 625 Speed of Operation
- ☐ 626 Storing/Stacking/Securing/Shoring
- ☐ 627 Stress
- ☐ 628 Tools (Hand/Non-Powered)
- ☐ 629 Tools/Equipment (Powered)
- ☐ 630 Training for Job/Task
- ☐ 631 Walking/Working Surfaces
- ☐ 632 Other Hazardous Condition
- ☐ 633 Other Unsafe Act Not Listed

SUPERVISOR'S COMMENTS AND CORRECTIVE RECOMMENDATIONS:

_____

_____

_____

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 099.33 Revised: 1-1-2001 Updated: 8-1-2006	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.
Street Address or P.O. Box	City		State	Zip Code

Child Support Obligation: ☐ Current ☐ Past Due Payable to:

EMPLOYER INFORMATION (Please Print)

City of Pine Bluff			
Employer's Name	Supervisor's Name		
200 East 8th Avenue	Pine Bluff	AR	71601
Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

			Date /Time
Place of Accident	Date of Accident	Time of Accident	Employer Notified of Accident

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

Name/address of witness(es): _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date _____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-S	ARKANSAS WORKERS' COMPENSATION COMMISSION	S
Authority: Ark. Code Ann. § 11-9-529 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

SUPPLEMENTAL REPORT

AWCC File No.	Carrier Claim No.	Employee Name (Last, First, MI)		Employee SS Number
City of Pine Bluff	71-6009954	Pine Bluff	AR	71601
Employer Name	FEIN No.	City	State	Zip Code
Municipal League Workers' Comp Trust		PO Box 37, North Little Rock, AR 72115		
Carrier Or Self-Insured Name	NAIC No.	Claims Office Address		

1. Date of injury: _____

2. Date employee began losing time from work: _____

3. Has employee returned to work? ❑ Yes ❑ No If yes, give date _____

4. If employee has returned to work, is he/she earning the same wages as before the injury? ❑ Yes ❑ No

   If not, please explain:

5. Has employee died? ❑ Yes ❑ No If yes, give date of death: _____

ADDITIONAL INFORMATION

CERTIFICATION

I certify that the information above is accurate according to the employer's/carrier's records.

Signature	Printed or Typewritten Name	Title	Date

MUNICIPAL EMPLOYEE'S REPORT OF ACCIDENT
mail to: **Municipal League Workers' Compensation Trust**
P.O. Box 37
North Little Rock, AR 72115

To be completed by employee:

PERSONAL: Name _____ Phone # _____ Birth Date _____
Last First Middle

Address: _____ Marital Status _____ Sex ___
Street City State Zip

EDUCATION: Circle highest grade level completed. 1 2 3 4 5 6 7 8 High School 9 10 11 12 College 1 2 3 4

Vocational Tech _____ Other _____

EMPLOYMENT: Present Employer _____ Job Title _____ Wages Wk _____

Length of Employment _____ If less than 5 years with present employer, list employers of past 5 years:

_____

_____

ACCIDENT: Date of Accident _____ Time _____ Place _____

Describe fully how accident happened _____

_____

Who did you report this accident to? _____ When? _____

Who witnessed the accident? _____

Who is your supervisor? _____

INJURY: Nature and location of injury (describe part(s) of body _____

_____

Name and Address of Doctor(s) _____

Who selected Your Doctor? _____ Date of First Visit _____

1st day unable to work? _____ Are you still under doctor's treatment'? _____

DISABILITY: How long does your doctor anticipate you will be off? _____

Are your wages continuing? _____ If so, from what source? _____

Regular wages, _____ Sick Leave, _____ Vacation _____

Have you ever collected compensation for a prior injury? ( ) yes ( ) no

If yes, give details _____

Have you ever had any other condition or injury involving this part of your body prior to this injury? ( ) yes ( ) no

If yes, give details _____

_____

Name and Address of Family Physician _____

I _____, received this day, a copy (front and back) of the Arkansas Workers' Compensation Form AR-N.

_____ _____
Employee Signature Date

_____ _____
Witness Witness

Use back for additional space.

Supervisor's Accident Investigation Form

This form should be completed by the department's supervisor any time an employee has a job-related accident.

Employee's Name: _____ Date of Hire: _____

Employee's Date of Birth: _____ Facility Treated By: _____

Incident Information		
Address:		
City:	Zip:	
Date of Incident:	Time Shift Started:	Time of Accident:
Job duties performing at the time of incident:		
Witness(es): *Attach statements if necessary*		

Accident/Injury Specific Information	
Nature of Injury:	Part of the Body Affected:
Activity when injury/accident occurred:	
Equipment/technique/industry standard used when accident occurred:	
Department policy/procedure violated (if any):	

Narrative

The IC or Supervising Officer's role is to document any injuries and/or the extent of damage caused by an accident. The department whose personnel were involved in the incident will conduct an investigation to determine cause and examine the circumstances surrounding the incident (who, what, when, & where). Attach additional paper if needed.

Submit completed report with workers' compensation packet before dismissal from duty

Supervisor's Signature: _____ Date: _____