

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

- 1 the disease manifests itself.
- 2 the employee is disabled as a result of the disease.
- 3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

- 1 the date of death.
- 2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

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www.laworks.net

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está deshabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene razones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes despues de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparece en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

Nombre y Dirección de la Compañía de Seguros

La notificación deberá ser dada ya sea llevándola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

Empleador

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.

Revisado Mayo 2003



WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)			LOCATION #
INDUSTRY CODE	EMPLOYER FEIN				PHONE #
CARRIER/CLAIMS ADMINISTRATOR					
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
		TO			
		CHECK IF APPROPRIATE			
		SELF INSURANCE <input type="checkbox"/>			
CARRIER FEIN		POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER					
EMPLOYEE/WAGE					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX		MARITAL STATUS	
		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		<input checked="" type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	
PHONE		# OF DEPENDENTS		OCCUPATION/JOB TITLE	
				EMPLOYMENT STATUS	
				NCCI CLASS CODE	
RATE PER:		<input type="checkbox"/> DAY	<input type="checkbox"/> MONTH	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?
		<input type="checkbox"/> WEEK	<input type="checkbox"/> OTHER:		<input type="checkbox"/> YES <input type="checkbox"/> NO
OCCURRENCE/TREATMENT					
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE () CANNOT BE DETERMINED	<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 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 SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
		WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)		INITIAL TREATMENT	
				<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HOURS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER					
WITNESSES (NAME & PHONE #)					
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg.

Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

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

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

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

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

**NOTICE
TO INJURED WORKERS**

YOU HAVE THE RIGHT TO CHOOSE YOUR OWN DOCTOR!

WHEN YOU ARE INJURED AT WORK OR BECOME SICK BECAUSE OF SOMETHING THAT HAPPENED AT WORK, THE LAW GIVES YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR IN ANY FIELD OR SPECIALTY OF MEDICINE FOR MEDICAL TREATMENT.

THE LAW ALSO ALLOWS YOUR EMPLOYER TO HAVE YOU SEE HIS/HER DOCTOR, BUT YOU DO NOT HAVE TO AGREE TO CONTINUE TREATMENT WITH YOUR EMPLOYER'S DOCTOR UNLESS THAT IS WHAT YOU WANT.

IF YOU WANT YOUR EMPLOYER'S DOCTOR TO CONTINUE TREATING YOU AFTER YOUR FIRST VISIT WITH HIM/HER, AND AFTER RECEIVING THIS FORM, YOU MAY CHOOSE YOUR EMPLOYER'S DOCTOR AS YOUR TREATING DOCTOR.

ONCE YOU CHOOSE EITHER YOUR EMPLOYER'S DOCTOR OR YOUR OWN DOCTOR AS YOUR TREATING DOCTOR, YOU MAY NOT BE PERMITTED TO CHOOSE ANOTHER DOCTOR IN THAT SAME FIELD OR SPECIALTY OF MEDICINE TO TREAT YOU FOR YOUR INJURY OR ILLNESS LATER ON. HOWEVER, YOU ARE NOT REQUIRED TO GET YOUR EMPLOYER'S APPROVAL TO CHANGE TO A DOCTOR IN ANOTHER FIELD OR SPECIALTY OF MEDICINE (La. R.S. 23:1121(B)(1)).

IF YOUR EMPLOYER DENIES YOUR RIGHT TO CHOOSE YOUR DOCTOR, YOU HAVE A RIGHT TO A SPEEDY HEARING BEFORE A WORKERS' COMPENSATION JUDGE TO RESOLVE THE DENIAL OF YOUR RIGHT (La. R.S. 23 1121 (B)(1) and 1124 (B)).

I HEREBY CHOOSE MY OWN DOCTOR TO TREAT ME FOR MY INJURY OR ILLNESS:
DR. _____.

OR

BY SIGNING THIS FORM, I STATE THAT I KNOW ABOUT MY RIGHT TO CHOOSE MY OWN TREATING DOCTOR, AND BEING SO ADVISED, I HEREBY ACCEPT AND CHOOSE TO CONTINUE TREATING WITH MY EMPLOYER'S DOCTOR:
DR. _____.

DATE

SIGNATURE OF EMPLOYEE

DATE

SIGNATURE OF EMPLOYER REPRESENTATIVE

(Note: If the employee is illiterate or has a language barrier, an authorized representative of the employer/insurer shall attest by their signature that this form and right of physician choice has been reasonably explained to that employee prior to his/her signature on this form. Failure to do so can jeopardize the employer's/insurer's right to subsequently refuse consent to the employee's request for treatment by a different physician within the same field or specialty.)