City of St. Augustine

Injury and Illness Report

Please complete all information

Name: _____ Date of Injury: _____

Phone: _____ Date of Birth: _____ Time of Injury: _____

Home Address: _____

Location/Address where injury/illness occurred: _____

Witnesses: _____

Specific Body Part Injured: _____
(left, right, lower, upper, etc.)

Any prior injuries to this body part? If yes, please explain

Describe Injury (pain, cut, bruise, swelling, etc.)

Describe the incident (please explain what you were doing prior to and **what caused the injury**):

Did you request medical treatment? Yes _____ No _____

Did you receive medical treatment? Yes _____ No _____

If yes, from whom: _____

Did you receive the worker's compensation information from your Supervisor? Yes _____ No _____

Please sign and date that the above information is correct and that you understand filing an injury claim containing any false or misleading information is insurance fraud:

_____
Employee Signature

****

Supervisors' Comments, Clarification, Additional Information, Could this have been prevented, Safety Violations:

Date Reported to Supervisor: _____ Time Reported: _____

Supervisor's Signature: _____ Reviewed by: _____

****

Human Resources:

Case #_____ Treated in ER: _____ Date of Hire _____ Rate of Pay: _____

Job: _____ FAMO DA, first day lost: _____

Confirmation #_____

WORKERS' COMPENSATION
EMPLOYEE ACKNOWLEDGEMENT OF
RESPONSIBILITIES AND DUTIES

I, _____, acknowledge that I am either currently receiving treatment under Workers' Compensation or if I elect to receive future treatment for the work-related injury sustained on_____, the following applies:

1. I will sign and return the **medical release** and **fraud form** sent by the worker's compensation carrier, the Florida League of Cities, or bring signed forms to Human Resources to submit. _____ Initial
2. I will return all phone calls & truthfully answer all questions from the Florida League of Cities. These calls will be coming from a 407 area code. _____ Initial
3. I understand that the restrictions set forth by my physician are valid both inside and outside of the workplace and I must comply with them at all times. _____ Initial
4. I understand that **the City provides 10-hours of follow up care**, so it is my responsibility to make appointments that reduce the amount of time I am out of work. After the City has paid 10-hours of follow up care, I can use sick, vacation, or other leave time – if applicable. _____Initial
5. I understand that my physician will provide the City with information regarding physical restrictions if I am unable to return to work in full capacity due to the nature of my injury. These limitations are outlined by my physician so that I may return to work as soon as possible while still achieving full recovery from my injury. The City will make every attempt to find me a suitable alternate/modified work assignment which will allow me to return to work in a capacity that meets these restrictions. _____ Initial
6. I understand that I must comply with any light duty assignment provided to me by my employer. I will be paid my regular hourly rate regardless of the limitations my doctor has set on duties performed. I further understand that these job duties are temporary in nature, and I may transition back to my regular job assignment once my doctor has determined I am capable. _____ Initial

RESPONSIBILITIES AND DUTIES
(Continued)

7. I acknowledge that if I refuse a light duty assignment, I am limiting my income. I will not be paid Workers' Comp and will use my accrued leave time until I am released to perform my regular work assignment. _____ Initial
8. I agree to keep Human Resources and my supervisor apprised of any changes in my physical restrictions and will advise of changes to my restrictions or my release to full duty by my physician immediately following the appointment or if it is after working hours, notification will be given the next working day. _____ Initial
9. I understand that all City policies, including attendance, punctuality and call off procedures will apply as usual during this transitional work period and failure to comply with the above may result in disciplinary action. _____ Initial

_____ _____
Signature Date

SPONSOR OF THE
FLORIDA MUNICIPAL
INSURANCE TRUST

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Mitchell **ScriptAdvisor**

"How to Guide" for Workers' Compensation *FIRST FILL* (Temporary Prescription Card)

EFFECTIVE APRIL 1, 2019...

Mitchell ScriptAdvisor has been selected to assist your injured employee in obtaining prescription drugs related to their workers' compensation claim.

This attached ***"FIRST FILL"*** letter enables your injured employee to fill prescriptions written by an authorized workers' compensation physician for medications related to their injury at the time of first reporting.

Utilization of the card should ensure that your employee has **NO out-of-pocket expenses** when filling their first prescription (*"first fill"*).

In addition, the attached "first fill" letter provides your injured employee instructions on how to utilize this *temporary prescription card for interim prescription filling* until a permanent prescription benefit card is established.

The only action items required to ensure your injured employee receive this letter at first report of their injury would be:

1. Make physical copies of this ***First Fill*** letter for any workers' compensation injury
2. Provide this letter to your injured employee via:
    - First Report of Injury Packet
    - Email
    - Website (loaded prior)
    - Hand directly to injured employee
3. Point out to the injured employee to take the *First Fill* letter to their local pharmacy *(instructions provided on First Fill letter)*

Mitchell **ScriptAdvisor**

First Fill – Temporary Prescription Card

FLORIDA LEAGUE OF CITIES

EFFECTIVE APRIL 1, 2019...

Mitchell ScriptAdvisor has been selected by **Florida League of Cities** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription.

For your convenience, **Mitchell** ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number or visit our website at www.mitchellscriptadvisor.com use the pharmacy locator.

Employee

- **You may contact Customer Service at 866.846.9279 OR you may simply hand this document to the Pharmacy/Pharmacist to request activation of your Temporary Prescription ID**
- Fill in the ID number supplied by Mitchell Customer Service along with your name on the ID card below.

Pharmacy

- To obtain the temporary Prescription ID, please contact Customer Service at 866.846.9279
- This sheet is a Temporary Prescription ID Card for a 5 Days' Supply Fill until this individual's permanent card can be provided.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor

Temporary Prescription Benefit Card

SCRIPT CARE, LTD.

Member Name:

Member ID #:

Rx BIN: 019082

PCN: MPS

Questions? Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury-related injuries covered under your insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

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