Newtown Police Department
191 South Main Street
Newtown, CT 06470

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TOWN OF NEWTOWN

APPENDIX A
Workman's Compensation
Procedures & Documentation

The following flowchart identifies the Workman's Comp reporting and documenting process for work place injuries. It is further detailed in P&P 1.23 Employee Injuries.

Work related Injury/Procedure/Etc.	Work related injury identified late
- Employee notifies supervisor immediately of any injury however slight. - Supervisor ensures appropriate medical treatment is given.	- Employee notifies on duty Shift Commander of injury at time it is noticed. - Employee will report to Town prescribed medical provider despite obtaining other medical treatment.

- Supervisor/Admin Lt notifies up the chain of command and to HR.
- Town of Newtown Injury Report, completed by supervisor.
- Supervisor documents with a Department Review number (DR#) and DR investigative report.
- It is the employee's responsibility to obtain the Town Medical Certificate and/or any other forms requested (available in PIN and Town Website).
- Employee is responsible for submitting an Employee Report of Injury Memo to supervisor.
- Employee is responsible for keeping the department informed of their work status.
- All forms must be received within 5 days of Dr visit/treatment.
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Workman's Compensation Paperwork

1. Employee Report of Injury Memo
- Completed by employee

2. Town Injury Report
- Completed by supervisor

3. Town Medical Certificate
- Completed by attending physician and returned to Admin Lt.
- Admin Lt will advise HR.

4. Form 30-C (optional)
- Injured employees may consider filling out a Worker's Compensation Packet (Form 30-C) see P&P 1.23 for details.

Notes

- All documents submitted to the department will be filed in the employee's medical file (Employee Report of Injury Memo, Town of Newtown Injury Report & Town Medical Certificate).
- It shall be the sole responsibility of the employee to ensure all forms are submitted to the proper persons on time (Medical Cert & Employee Report of Injury Memo).
- Failure to submit any of the forms on time may result in delay and/or denial of benefits.

TOWN OF NEWTOWN
INJURY REPORT

Copy to: Department Head, Human Resource

☐ Incident Only ☐ First Aid ☐ Physician/Hospital

Employee's Name		Address	
Date of Birth	Social Security Number	Date of Hire	Job Title
Home Phone	Work Phone	Time Employee Began Work	
Body Part Injured		Treatment Received	

Location of Incident	Date: Time:
Injury Reported to	Date: Time:

Witnesses to Incident

Describe fully how the accident occurred and what employee was doing when injured. Include description of work, tools, and personal protective equipment in use. Also indicate any unsafe conditions observed during investigation.

Was personal protective equipment required and in use? ☐ Yes ☐ No If No, explain why not:

Causal factors (List all factors that contributed to this incident.)

Given the immediate conditions, what steps could have been take to prevent this injury?

What has been done to prevent similar accidents from recurring?

Immediate Actions:

Long Term Actions:

Target date (s) for corrective actions and person responsible

Supervisors Signature _____ Title _____ Date:

Department Head Signature _____ Date

TOWN OF NEWTOWN

MEDICAL CERTIFICATE

The employee shall give this form to his/her physician or medical practitioner. The form will be returned to the following address:

Office of the Chief of Police
Newtown Department of Police Services
191 South Main Street
Newtown, Connecticut 06470 **FAX # 203-270-3779**

The attending physician or medical practitioner is requested to complete the form in order that the Newtown Department of Police Services will be better able to administer the duty status of the following named employee:

Name of Patient: _____ Physician's Name: _____

Date of Examination: _____ Physician's Address: _____

Injury or Illness (optional) _____

Please check off and provide information that pertains to this patient. This information provided should be time period specific allowing the agency to determine the employee's work status on a day-to-day basis or for a specific time period:

☐ The Patient, after an examination on: _____, is physically **able** to return to Full Duty as a police officer or civilian employee (if you require a list of duties and responsibilities to make this determination please contact the Office of the Chief of Police). **Date of return to full duty status**: _____

☐ The Patient, after an examination on: _____, is physically **unable** to perform (1) the full time duties of a Newtown Police Officer or (2) the duties of a civilian employee or (3) in a light duty capacity. ** The Town of Newtown reserves the right to send the patient for a second opinion regarding light duty status at the Town's expense.

☐ The Patient, after an examination on: _____, is physically **able** to perform Light-Duty. (Light-Duty work is available at the Newtown Department of Police Services for a variety of restrictions and with modified work hours, subject to availability).

Restrictions related to Light-Duty if any: _____

_____

_____

*The date of the next appointment for the patient to be re-evaluated regarding his work status: _____

OR

*Patient referred to a specialist (yes or no). Date of appointment with specialist: _____

Any additional comments: _____

_____ _____

Physician's Signature Date

*Must be filled in if the employee is not returned to full duty status.

The **Return to Work Program Questionnaire must be filled out and returned with the Medical Certificate. (Rev 3/21)

State of Connecticut Workers' Compensation Commission

This form prepared by the WCC is proper for ordinary use and is recommended, but any other notice complying with Section 31-294c shall be deemed sufficient.

Rev. 01-31-2018

30C

Notice of Claim for Compensation

(Employee to Commissioner and to Employer)

Notice is hereby given that the injured worker, while in the employ of the employer, sustained injuries arising out of and in the course of his/her employment as follows, and makes claim for compensation benefits.

Please TYPE or PRINT IN INK

WCC File #

Date filed in District

(for WCC use only)

INJURED WORKER

Name _____
(first) *(middle)* *(last)*

D.O.B. *(required)* _____

Check, if a Minor ❑ *(under 18 yrs. of age)*

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

INJURY

Date of Injury _____

Town of Injury _____

Body Part(s) _____

Describe Injury and How It Happened:

❑ Check, if an Occupational Disease or a Repetitive Trauma

❑ Check, if you have MORE THAN ONE Employer

EMPLOYER

Employer _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

Was Injury ON Premises of Employer? ❑ YES ❑ NO

If NO, where? _____

Address _____

Town _____

Zip Code _____ Tel.# _____

SIGNATURE OF INJURED WORKER OR REPRESENTATIVE

Signature _____

Date _____

Print name & address below, if other than injured worker:

Name _____

Name of Firm _____

Address _____

Town _____ State _____

Zip Code _____ Tel.# _____

This notice must be served upon the Commissioner and *Employer by personal presentation or by registered or certified mail. For the protection of both parties, the employer should note the date when this notice was received and the claimant should keep a copy of this notice with the date it was served.

* *Persons employed by the State of Connecticut must serve the employer by serving this notice upon the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103.*

* *Persons employed by a municipality must serve the employer by serving this notice upon the town clerk of the municipality in which he or she is employed.*

* *If your employer pursuant to statute has posted the location where this notice is to be filed, it is your obligation to file it at that location, using certified mail.*

WARNING: If an employer does not file a notice contesting liability (e.g. Form 43) for this claim OR begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date when this claim is received by personal delivery or by registered or certified mail, COMPENSABILITY SHALL BE PRESUMED and cannot thereafter be contested. If an employer chooses to begin making workers' compensation benefit payments "without prejudice" within 28 calendar days from the date of receipt of this claim and still wishes to contest this claim, it must do so by filing a notice contesting liability for this claim within one year from receipt of this claim. [See Sec. 31-294c(b).]

A 30C Form should be filed promptly after a work-related injury or illness takes place. There is a statute of limitation for filing workers' compensation claims: within **one** year of the date of an accidental injury or within **three** years from the first manifestation of a symptom of an occupational disease.

[**NOTE**: If, within the applicable time period described above, (1) there has been a hearing or a written request for a hearing or an assignment for a hearing or (2) your employer's insurance carrier has already signed a Voluntary Agreement, you do **NOT** need to file a 30C Form for the injury or illness it covers.]

You Should File A 30C Form Because . . .

- There will be no doubt that you are claiming that you have a work-related injury or occupational disease.
- It is the best way to insure that you have met the statute of limitations for filing a workers' compensation claim.
- A simple "accident report" filed with the employer is not an official claim for workers' compensation.
- Your claim will be more likely to receive prompt attention from your employer or insurance carrier.
- Once your employer receives an official claim, they have only 28 calendar days in which to either deny your claim or to begin making workers' compensation benefit payments "without prejudice." If an official denial is not issued within 28 calendar days or if benefit payments are not initiated within 28 calendar days, your employer must accept the compensability of your claim. (If your employer has opted to post a location where you must file your claim, this 28-day period begins when your employer has received your claim *at the location posted* per statute.)

Directions for Completing the 30C Claim Form

Please pay close attention to these directions. Remember to Type or Print Neatly In Ink (except for signatures).

In filling out the 30C Form, please note the following:

1. **In the "INJURED WORKER" box** at the upper left side of the form, **type or neatly print the name of the injured worker (If YOU are the injured worker, print YOUR name here.). Also fill in the injured worker's D.O.B.** (date of birth), **put a check in the box if the worker is a minor** (under the age of 18), **and fill in the injured worker's street address, town, state, zip code, and telephone number**.
2. **In the "EMPLOYER" box** at the lower left side of the form, **type or neatly print the name of the employer** ("Name of employer" means the name of the organization for which you work, NOT your boss or supervisor.) **and its street address, town, state, zip code, and telephone number**. **Next indicate** (YES or NO) **whether the injured worker's injury occurred at the employer's location just listed; *if the injury took place at a location other than that listed*, fill in the location, street address, town, state, zip code, and telephone number where the injury actually occurred**.
3. **In the "INJURY" box** at the upper right side of the form, **type or neatly print the date of the injured worker's injury and the town in which the injury occurred** (Note the city or town in which the injury actually occurred. This will not necessarily be the same location as the employer's business address!). **Next indicate the part(s) of the worker's body injured and how the injury occurred** (In the blank space describe your injury in simple terms. Indicate the part(s) of your body affected and the type(s) of injury. For example: "sprain to the right shoulder", "amputation of the left thumb", "fracture of the right ankle", "severe strain to lower back", etc.). **Lastly, indicate** (YES or NO) **whether the injury is an occupational disease or a repetitive trauma, and check the appropriate box, if you have more than one employer**.
4. **In the "SIGNATURE OF INJURED WORKER OR REPRESENTATIVE" box** at the lower right side of the form, **sign your name and fill in the date of your signature, if you are the injured worker. *If you are NOT the injured worker*, then sign your name, fill in the date of your signature, and then type or neatly print your name, the name** (if any) **of your firm, your street address, town, state, zip code, and your telephone number**.
5. **In the "WCC File #" box** at the upper right side of the form (just below the "30C" number in the upper right corner), **type or neatly print the WCC File Number, ONLY IF YOU KNOW IT**. In most instances, this number will be assigned to your claim by the Workers' Compensation Commission only after you send the 30C Form in, so **it is okay to leave this one area of the form blank, if you are not absolutely sure of the number**.

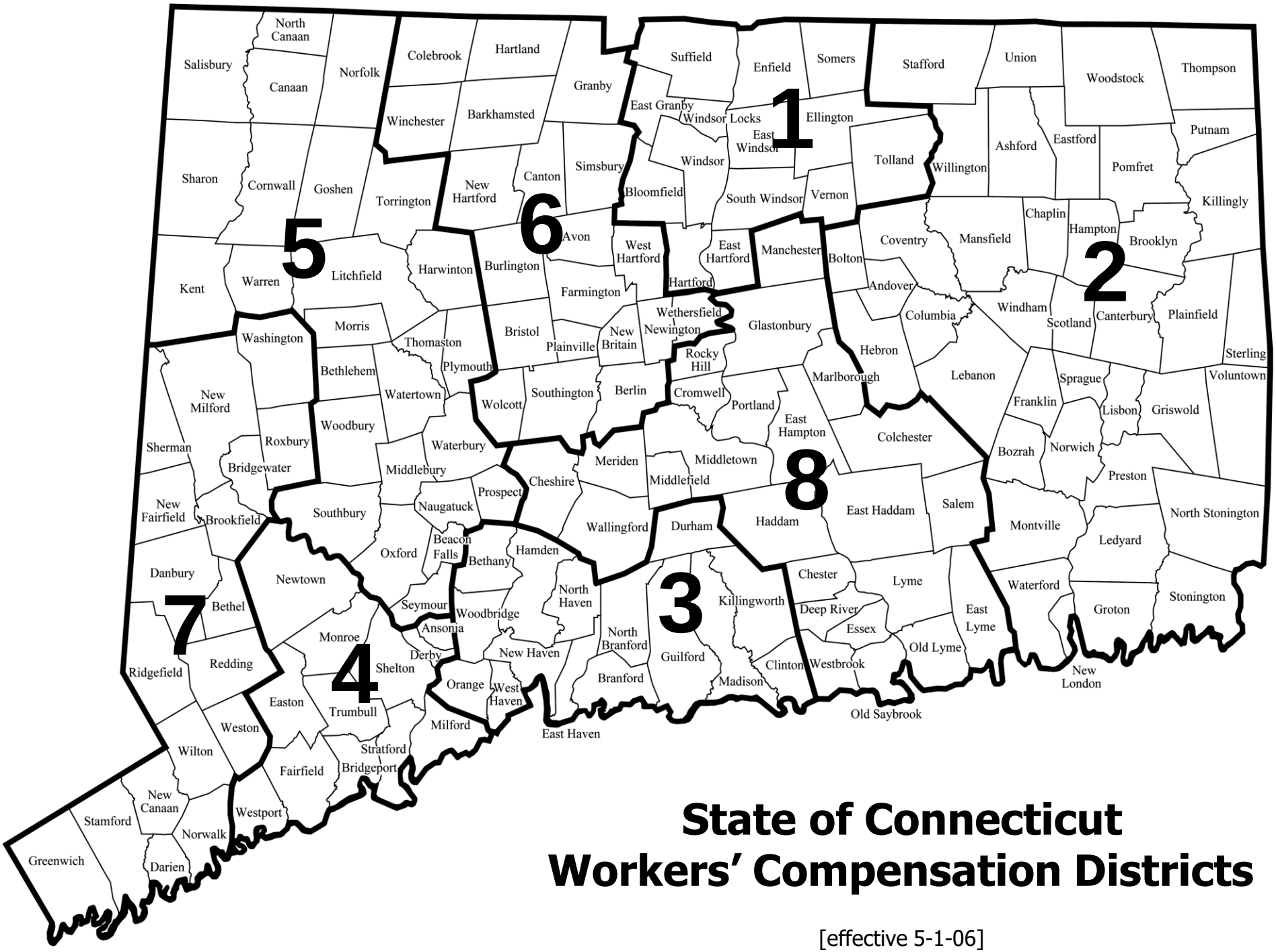
Once you have completed the 30C Form, follow these procedures:

6. **Make two (2) extra copies of your completed 30C Form** (this can be done at many quick-copy printers).
7. **Send the original 30C to your employer* by Certified or Registered mail, return receipt requested. The claim may also be delivered in person but if so, have the employer acknowledge in writing the receipt of the claim.**

   **** State employees**' work-related injuries and illnesses are reported on Form PER-WC 207, entitled "Report of Occupational Injury or Disease to an Employee". If a State employee elects to file a 30C Form, then he or she must send the 30C Form to the Commissioner of Administrative Services, 450 Columbus Boulevard, Hartford, CT 06103, NOT to the particular office where employed. (The Form PER-WC 207 is ONLY an accident report and is NOT the official claim form for workers' compensation benefits — State employees, like any other employees, must file a 30C Form in order to file an official workers' compensation claim.)*

   **** Municipal employees**, like any other employees, must file a 30C Form in order to file an official workers' compensation claim; if a municipal employee elects to file a 30C Form, then he or she must send the 30C Form to the town clerk of the municipality in which he or she is employed.*

   **** Employees (other than State or municipal employees):** if your employer pursuant to statute has posted the location where you must file a 30C Form, it is your obligation to file it at that location, using certified mail.*
8. **Send a copy of the 30C to the appropriate Workers' Compensation Commission District Office by Certified or Registered mail, return receipt requested, or deliver by personal presentation.** Addresses for all Workers' Compensation Commission District Offices may be found in this packet of material. **The "District Office" refers to the number given to the District Workers' Compensation Commission Office for the town in which you were injured**. Refer to the Connecticut map provided with the Form 30C for the number of the Compensation District for the town in which you were injured.
9. **Keep the remaining copy of the 30C for your own file.**



State of Connecticut
Workers' Compensation Districts

[effective 5-1-06]

Workers' Compensation Commission District Offices

District 1 — Hartford

999 Asylum Avenue
Hartford, CT 06105

Phone: (860) 6
Fax: (860) 5

District 2 — Norwich

55 Main Street
Norwich, CT 06360

Phone: (860) 8
Fax: (860) 8

District 3 — New Haven

700 State Street
New Haven, CT 6 Phone:

(203) 7
Fax: (203) 789-7168

District 4 — Bridgeport

350 Fairfield Avenue
Bridgeport, CT 6

Phone: (203) 3
Fax: (203) 3

District 5 — Waterbury

55 West Main Street
Waterbury, CT 0

Phone: (203) 596-4207
Fax: (203) 805-6501

District 6 — New Britain

233 Main Street
New Britain, CT 6

Phone: (860) 8
Fax: (860) 827-7913

District 7 — Stamford

111 High Ridge Road
Stamford, CT 0

Phone: (203) 325-3881
Fax: (203) 967-7264

District 8 — Middletown

90 Court Street
Middletown, CT 06457

Phone: (860) 344-7453
Fax: (860) 344-7487