Prepared by the Office of Human Resources.
This replaces Administrative Procedure No. A9.720
dated December 1996.

July 1999

WORKERS' COMPENSATION

A9.720 WORKERS' COMPENSATION

1. Purpose

To set forth procedures for reporting work-related injuries and illnesses of individuals eligible for coverage pursuant to Chapter 386, HRS, Hawai'i Workers' Compensation Act, and Title 12, Chapter 13, Hawai'i Administrative Rules

2. Objectives

a. To prescribe the systemwide procedures for reporting work-related injuries/illnesses

b. To prescribe and provide the necessary forms and supporting documents to report work-related injuries/illnesses and to support benefit claims

3. References

a. Chapter 386, HRS, Hawai'i Workers' Compensation Law

b. Title 12, Chapter 13, Hawai'i Administrative Rules

c. Highlights of the Hawai'i Workers' Compensation Law, Department of Labor (Rev. 2/95)

d. Administrative Procedure, A9.750, University Health and Safety Program

e. Chapter 90, HRS, State Policy Concerning the Utilization of Volunteer Services

f. Administrative Procedure, A9.041, Utilization of Volunteer Services at the University of Hawai'i

g. Section 302A-430,HRS, Coverage for Workers' Compensation

4. Applicability/Responsibility

a. This procedure applies, as appropriate, to:

1) All Board of Regents (BOR) and Civil Service employees of the University of Hawai‘i

2) Official volunteers, as defined in accordance with Administrative Procedure, A9.041, Utilization of Volunteer Services at the University of Hawai‘i, while providing services to the University of Hawai‘i, provided that they have not received any payment for hospital and medical expenses from the State, County or any other person

3) Students participating in an approved school-to-work program sponsored by the University of Hawai‘i who performs work for a private employer as part of the student’s work-based learning program, whether paid or unpaid

b. The Office of Human Resources (OHR), Workers’ Compensation Section, is responsible for administering the University’s workers' compensation program.

c. The OHR may utilize the services of a third party administrator (TPA) for case management and claims adjustment, as appropriate.

d. The supervisor of the injured employee shall timely advise and assist the employee in securing medical attention, filing of the report of injury/illness, notifying the Personnel Officer, Administrative Officer or Designated Workers’ Compensation Coordinator of the injury/illness, and submitting required documents. (See listing of forms on last page.)

e. The Personnel Officer, Administrative Officer or Designated Workers’ Compensation Coordinator (PO/AO/Designee) shall advise the supervisors and employees of the Worker’s Compensation Law and applicable administrative rules and University procedures pertinent to the reporting of work-related injuries/illnesses and shall serve as the point of contact for the OHR and the TPA.

5. Guidelines

The purpose of Chapter 386, HRS, Hawaiʻi Workers' Compensation Law, is to provide compensation to employees for economic losses due to occupational injuries/illnesses arising out of and in the course of employment. The injury/illness must be work-related in order to be compensable.

a. Reporting Requirements

1) Under the workers' compensation law, each work-related injury/illness causing an absence of one or more days or which requires medical services other than first aid treatment must be reported by the University within seven (7) working days to the Disability Compensation Division (DCD) of the State Department of Labor and Industrial Relations (DLIR). The seven (7) working days reporting period begins from the first day the employer has knowledge of the occurrence of the injury/illness. For purposes of reporting work-related injuries/illnesses, the employer is defined as the injured employee's supervisor.

2) To report an injury/illness of a person other than an employee, i.e., student or visitor, while on University premises, the person reporting the injury/illness shall complete UH Form 29 (H&S), Accidental Injury and Occupational Illness Report, in accordance with Administrative Procedure, A9.750, University Health and Safety Program, and submit the report directly to the respective Campus Safety Office.

6. Procedures

The following procedures shall apply to the University's Workers' Compensation program.

a. An injured employee shall:

(1) report any work-related injury/illness to the supervisor immediately after it occurs, or as soon thereafter as possible

(2) complete and submit to the supervisor the UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1)immediately or as soon thereafter as possible

(3) complete and submit to the PO/AO/Designee concurrently with the UH Form 79 or separately shortly thereafter other documents as specified below:

- UH Form 41, Notification and Election of Compensation for Work-Related Injury/Illness (Attachment 3)

- State Accounting Form D-60, Salary Assignment/Cancellation (for contributory retirement plan members only) if the employee elects to have retirement contributions deducted from the workers' compensation benefit payments (Attachment 4)

(4) timely submit to the PO/AO/Designee any disability certifications from the treating physician

(5) upon receipt from the PO/AO/Designee, review the copies of the "Highlights of the Hawai‘i Workers' Compensation Law" brochure (Attachment 5) and "What To Do When You Are Injured" information sheet (Attachment 6)

(6) once the claim is determined to be compensable, complete and submit to the PO/AO/Designee the appropriate forms to claim time-off for medical treatment (Attachment 7)

(7) submit directly to the TPA for its consideration requests for reimbursements of out-of-pocket expenses

(8) timely inform the PO/AO/Designee and the TPA of any changes in address; failure to do so may delay the receipt of benefits

b. When notified of the injury/illness, the supervisor shall:

(1) provide to the injured employee the UH Form 79, Report of Work-Related Injury/Illness (Attachment 1)

(2) as appropriate, facilitate the reporting by assisting the injured employee in the completion of the employee's statement on the report form

(3) encourage the employee to seek medical attention, if necessary

(4) complete the supervisor's statement on the UH Form 79 (OHR)(Attachment 1), Report of Work-Related Injury/Illness, and forward it immediately to the respective PO/AO/Designee

(5) if claim is deemed compensable and, as applicable, complete and submit the UH Form 83, Time-Off for Treatment of Work-Related Injury/Illness (Attachment 7)

c. The PO/AO/Designee shall:

(1) file the report of injury/illness either telephonically or by FAX to the TPA on the prescribed form (Attachment 2)

Note: If the injury/illness does not involve medical treatment beyond first aid and/or lost work time, do not file the report with the TPA. Submit the Report of Work-Related Injury/Illness (Form 79) to OHR for "records only" documentation.

(2) inform the employee of the basic rights and benefits under Workers' Compensation Law by providing the employee with copies of the "Highlights of the Hawai'i Workers' Compensation Law" brochure (Attachment 5) and "What To Do When You Are Injured" information sheet (Attachment 6)

(3) be cognizant of the statutory requirement that the TPA must file on behalf of the University the WC-1 Employer's Report of Industrial Injury with the State Department of Labor and Industrial Relations no later than seven (7) working days after the injured employee notifies the supervisor of the injury and that the failure of the University to report promptly is a misdemeanor punishable by not more than a $5,000 fine. The PO/AO/Designee will, therefore, make every effort to comply with the law

(4) ensure that the following forms and supporting documents are accurately prepared and submitted to the University OHR immediately after the reporting of the injury to the TPA:

- UH Form 42, Computation of Average Weekly Wages for Temporary Disability Payments (Attachment 8)

  This form showing the breakdown by object codes should support the wage information included in the initial report to the TPA.

- Copy of the employment document in effect at the time of injury/illness; e.g., UH Payroll Notification Form (PNF), State DPS Form 5 Notification of Personnel Action (SF-5), UH Form 6, FMIS-36, Student Employment Work Agreement (SEWA), Volunteer Application Form, etc.

- UH Form 41 (OHR), Notification and Election of Compensation for Work-Related Injury/Illness (Attachment 3)

- UH Form 78 (OHR), Workers' Compensation Industrial Injury Leave Worksheet (Attachment 9)

  Complete this form only when there is lost work time due to the injury/illness. Complete this form initially for the entire month.

On an on-going basis, if the claim is deemed compensable, the following should be submitted:

- UH Form 78 (OHR) Workers' Compensation Industrial Injury Leave Worksheet (Attachment 9) for each subsequent pay period. This document serves as the basis for determining wage replacement benefits.

- Disability certifications from treating physicians

- Any forms submitted by the injured employee relative to the claim; e.g.,disability certifications, updated UH Form 41, etc.

d. The Office of Human Resources shall facilitate, coordinate and oversee the comprehensive University systemwide case management program to ensure that all benefits to which the injured employee is entitled under the Hawaiʻi Workers' Compensation Law are timely and appropriately provided. The designated TPA shall, on behalf of the OHR, shall timely file the Form WC-1, Employer's Report of Industrial Injury, and determine the compensability of the claim. The OHR shall forward a copy of the WC-1 to the PO/AO/Designee who shall then provide a copy to the employee.

e. The responsibility of the TPA shall include, but not be limited to, initiating, maintaining and updating a comprehensive systemwide case management and claims adjustment program to ensure prompt compensation of benefits to eligible injured employees under the Hawaiʻi Workers' Compensation Law.

7. Forms

a. UH Form 79 (OHR), Report of Work-Related Injury/Illness (Attachment 1)
b. Workers' Compensation Reporting Worksheet(Attachment 2)
c. UH Form 41 (OHR), Notification and Election of Compensation for Work-Related Injury/Illness (Attachment 3)
d. State Accounting Form D-60, Salary Assignment/Cancellation (for contributory retirement plan members only, to be completed only if employee elects to have retirement contribution deducted from the workers' compensation pay)(Attachment 4)
e. "Highlights of the Hawaiʻi Workers' Compensation Law" (Attachment 5)
f. "What To Do When You Are Injured" information sheet (Attachment 6)
h. UH Form 83 (OHR), Time-Off for Treatment of Work-Related Injury/Illness (Attachment 7)
i. UH Form 42 (OHR), Computation of Average Weekly Wages for Temporary Disability Payments (Attachment 8)
j. UH Form 78 (OHR), Workers' Compensation Industrial Injury Leave Worksheet (Attachment 9)

University of Hawai‘i
REPORT OF WORK-RELATED INJURY/ILLNESS

I. Employee’s Statement

Name: _____ Dept/College: _____
Last First M.I.

Home Address: _____ Marital Status: Married ( ) Single ( )
Street/P.O.Box

_____ Home Phone: _____ Work Phone: _____
City State Zip

Date of Injury: _____ Time of Injury: _____ a.m. _____ p.m.
mo day year

Date injury/illness reported to Supervisor: _____ Name of Supervisor: _____

List names and phones numbers of any witnesses to injury/illness: _____

_____

Any outside employment? Yes [ ] No [ ] If yes, list name and address of employer:

_____

Did you lose any time off from work? Yes [ ] No [ ] If yes, indicate dates: From _____ To _____

Fully describe how, when and where the injury occurred (e.g., I was in Hawai‘i Hall Room 5 moving a 60# box of copier paper from the bottom shelf to the hand truck when I felt a sharp pain):

_____
_____
_____
_____

Identify body part and extent of injury/illness (e.g., muscle strain in lower back):

_____
_____

If you received medical treatment other than first aid, provide name and address of medical provider:

_____

If you were hospitalized for this injury/illness, provide name and address of hospital: _____

_____

Have you ever had a similar injury/illness? Yes [ ] No [ ] If yes, please explain and list names and addresses of previous medical providers who have treated you: _____

_____
_____

If you have ever been hospitalized prior to this injury/illness, please provide the following information:

Hospital	Reason for Hospitalization	Date(s)

I hereby certify that the statements on this form are true and correct to the best of my knowledge.

_____ _____
Employee’s Signature Date

II. Supervisor's Statement

Date on which the injury/illness described above was reported to you: _____

Is the Employee's description of his work assignment at the time of injury accurate? Yes [ ] No [ ]
If no, explain: _____

Was the Employee performing the assigned duties and responsibilities at the time of injury/illness?
Yes [ ] No [ ] If no, explain: _____

If applicable, identify the tools, equipment, or materials that the employee was using at the time of the accident:

Was the cause of the accident due to any of the following; check those that apply?:
[ ] unsafe act(s) [ ] unsafe condition(s) [ ] defective equipment/tool
Elaborate on any answers above (e.g., "unsafe act" - changing the cutting line on a weed whacker without turning off the engine; "unsafe condition" - operating the weed whacker without safety goggles; "defective condition" - operating a weed whacker with a cracked guard shield):_____

Indicate below the type of personal protective equipment issued to the Employee and if used at the time of accident:

	Issued	Used		Issued	Used
safety glasses	[ ]	[ ]	respirator	[ ]	[ ]
goggles	[ ]	[ ]	type: _____		
hard hat	[ ]	[ ]	foot protection	[ ]	[ ]
face shield	[ ]	[ ]	type: _____		
ear muffs/plugs	[ ]	[ ]	clothing	[ ]	[ ]
gloves	[ ]	[ ]	type: _____		
other: _____	[ ]	[ ]			

Provide any other relevant information which may assist in the determination of compensability: _____

_____	_____	_____	_____
Supervisor's Name (print)	Supervisor's Signature	Phone No.	Date

III. Designated Workers' Compensation Coordinator (College AO/PO)

1. Immediately complete the Worksheet for Worker's Compensation Telephone Reporting and submit to Constitution State Services Company (CSSC) either by FAX or by telephone. Information not provided in Parts I and II above should be provided from the Employee's personnel file (e.g., marital status, account code, SSN, position title). Do not wait for the supporting documents listed below.
2. Do **not** submit this form (UH Form 79) to CSSC. Submit to the UH Office of Human Resources (OHR), with or without the following documents; if without, submit as soon as possible:
   - UH Form 78, Worker's Compensation Industrial Injury Leave Worksheet
   - Copy of current appointment document (PNF, SF-5, Form 6, FMIS-36, SEWA)
   - UH Form 42, Computation of Average Weekly Wages for Temporary Disability
   - UH Form 41, Notification and Election of Compensation for Work-Related Injury/Illness

   I hereby certify that I have timely filed the report of injury/illness with CSSC and have provided the requisite documentation to UH-OHR and that I have provided the Employee with a copy of the brochure titled "Highlights of Hawai'i Workers' Compensation Law" and the information sheet titled "Basic Rights and Benefits."

_____	_____	_____	_____
AO/PO/Designee Name (print)	AO/PO/Designee Signature	Phone	Date

WORKERS' COMPENSATION REPORTING WORKSHEET

A9.720

Attachment 2

FAX NUMBER: [808] 540-3892

TELEPHONE REPORTING NUMBER: [800] 243-2490

THINGS TO REMEMBER WHEN COMPLETING THE INFORMATION BELOW:

Call the Telephone Reporting Center to quickly and easily report all Workers' Compensation injuries. We will be asking you the following questions, so please have the information handy. We will produce and submit the necessary state forms. **AFO : 065 / HONOLULU**

ACCOUNT / ACCIDENT INFORMATION

CALLER'S PHONE NUMBER / EXTENSION	CALLER'S TITLE	CALLER'S NAME	REPORTING STATE
( )			**HAWAII**

DEPARTMENT NAME	DEPARTMENT ADDRESS (STREET, CITY, STATE & ZIP)	DEPARTMENT MAILING ADDRESS (STREET, CITY, STATE & ZIP)
		SAME

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?

☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME

UNIVERSITY OF HAWAII, 2440 CAMPUS RD; HONOLULU, HI 96822

ORG Code = 6 DIGITS	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS
	CUCSSC 240T6150	**HIGHER EDUCATION**

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER
		☐ MALE ☐ FEMALE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S HOME PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)
( )	

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE	INJURED WORKER TYPE	REGULAR OCCUPATION
☐ FULL-TIME ☐ PART-TIME ☐ OTHER _____	N/A	

OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS HOURS/DAY DAYS/WEEK

EMPLOYEE'S WAGE INFORMATION:

$ _____ / HOUR OR $ _____ / MONTHLY OR $ _____ / WEEKLY ADDITIONAL COMPENSATION: $ _____.

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	BEST HOURS TO CONTACT
	( )	

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK?	IS THE EMPLOYEE BACK AT WORK?
	☐ YES ☐ NO	☐ YES ☐ NO IF YES, DATE RETURNED TO WORK?

RETURN TO WORK STATUS	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH
☐ LIGHT ☐ MODIFIED ☐ REGULAR		☐ YES ☐ NO

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)	CONTRIBUTING FACTORS

EQUIPMENT, MATERIAL OR SUBSTANCE INVOLVED

IF OTHER PEOPLE WERE INVOLVED

NAME (FIRST, MI, LAST) ADDRESS PHONE NUMBER

IS DESCRIPTION OF INCIDENT ACCURATE ?

☐ YES ☐ NO

XC: OHR C-23437 6/99

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	ADDRESS	PHONE NUMBER

INJURY INFORMATION

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, DESCIBE)

☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY

☐ FIRST AID —	TREATMENT AND DATE OF 1ST TREATMENT
☐ HOSPITAL/ CLINIC —	NAME, ADDRESS, PHONE NUMBER, PHYSICIAN NAME, TREATMENT, DATE OF 1ST TREATMENT, LENGTH OF STAY, AMBULANCE USED?
☐ PHYSICIAN —	

STATE SPECIFIC QUESTIONS: HAWAII

Department of Labor Number: **S000000700**

Medical deductible: **NONE**

CUSTOMER SPECIFIC INFORMATION

EMPLOYEE'S BARGAINING UNIT # (2 Digits): _____

14 DIGIT PAYROLL ACCOUNT CODE + % TO BE CHARGED [may be up to 5 codes]

1ST PAYROLL ACCT CODE:
% TO BE CHARGED:
2ND PAYROLL ACCT CODE:
% TO BE CHARGED:
3RD PAYROLL ACCT CODE:
% TO BE CHARGED:
4TH PAYROLL ACCT CODE:
% TO BE CHARGED:
5TH PAYROLL ACCT CODE:
% TO BE CHARGED:

ADDITIONAL COMMENTS & INFORMATION

CONCURRENT EMPLOYMENT ?

University of Hawai‘i

NOTIFICATION AND ELECTION OF COMPENSATION FOR WORK-RELATED INJURY/ILLNESS

Name: _____Dept/College: _____ Date of Injury: _____

I understand that workers' compensation (WC) wage loss replacement benefits will be made from the 4th day of disability. I understand that the first three days of absence due to disability must be charged to personal leave (sick, vacation or leave without pay). I further understand that the wage loss replacement shall be for periods of authorized temporary total disability (TTD) or temporary partial disability (TPD) at the rate of 2/3 of my weekly wages not to exceed the specified State maximum and that the University provides for supplementation of this benefit with vacation and sick leave with the intent to provide me with an amount equivalent to a full paycheck. With this understanding, I hereby make the following election effective the date of signature below to the day my disability ends, unless superseded in writing on a subsequent election:

Option 1 _____ WC Benefits (66⅔% of weekly wages, not to exceed the specified State maximum)
TTD/TPD benefits only. Do not use my accumulated sick and/or vacation leave credits.

Option 2 _____ WC Benefits + Sick/Regular Pay = Regular Salary (100%)
TTD/TPD benefits plus salary payments, consisting of sick and/or regular pay to equal my regular salary. My accumulated sick leave credits will be used on a pro-rata basis. Do not use my accumulated vacation leave credits. If I do not have sufficient accumulated sick leave credits to receive a sum equal to my full salary, I will receive an amount equal to worker's compensation benefits plus regular pay for any days worked plus available sick leave pay.

Option 3 _____ WC Benefits + Vacation/Regular Pay = Regular Salary (100%)
TTD/TPD benefits plus salary payments, consisting of vacation and/or regular pay to equal my regular salary. My accumulated vacation leave credits will be used on a pro-rata basis. Do not use my accumulated sick leave credits. If I do not have sufficient accumulated vacation leave credits to receive a sum equal to my full salary, I will receive an amount equal to worker's compensation benefits plus regular pay for any days worked plus available vacation leave pay.

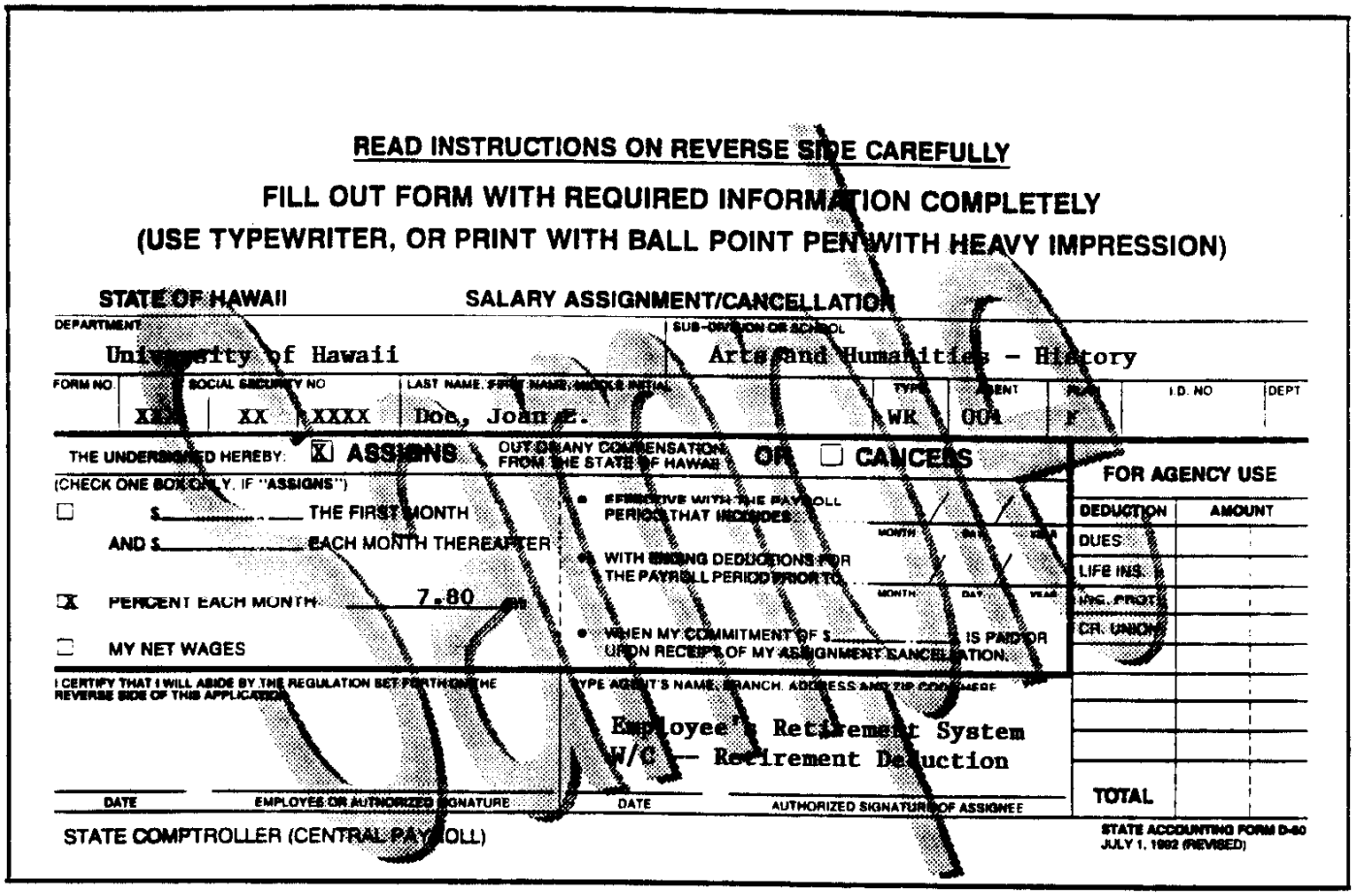
Option 4 _____ WC Benefits + Sick/Vacation/Regular Pay = Regular Salary (100%)
TTD/TPD benefits plus salary payments, consisting of regular pay, and available sick and vacation pay to equal my regular salary. My accumulated vacation leave credits will also be used on a pro-rata basis if my accumulated sick leave credits are insufficient. If I do not have sufficient accumulated sick and vacation leave credits, I will receive a sum equal to workers' compensation benefits, regular pay for days worked, and available sick and vacation leave pay.

Option 5 _____ WC Benefits + Regular Salary (Regular/Vacation Pay) = 166⅔%
TTD/TPD benefits plus my regular salary, consisting of regular pay and vacation pay. For example, if I am totally disabled, my absence due to WC disability will be charged fully to vacation leave (approximately 100%) and, additionally, I will receive WC benefits (approximately 66⅔%). Do not use my accumulated sick leave credits.

For contributory plan members only: I also understand that I have the option to authorize deductions from my workers' compensation payments for contributions to my contributory retirement plan.
I hereby (*check one)* elect _____ do not elect _____ to have retirement system deductions withheld. A completed State Accounting Form D-60, Salary Assignment/Cancellation is attached to effect my election to have retirement system contributions withheld.

Where the total deductions from my salary payments are insufficient to cover all voluntary deduction items, I shall make payments directly to the respective payees as soon as possible. I understand that no deductions from my workers' compensation wage replacement benefits can be made.

_____ _____
Signature of Employee Date



READ INSTRUCTIONS ON REVERSE SIDE CAREFULLY

FILL OUT FORM WITH REQUIRED INFORMATION COMPLETELY

(USE TYPEWRITER, OR PRINT WITH BALL POINT PEN WITH HEAVY IMPRESSION)

STATE OF HAWAII — SALARY ASSIGNMENT/CANCELLATION

DEPARTMENT: University of Hawaii

SUB-DIVISION OR SCHOOL: Arts and Humanities - History

FORM NO.	SOCIAL SECURITY NO	LAST NAME, FIRST NAME, MIDDLE INITIAL	TYPE	AGENT	PLAN	I.D. NO	DEPT
XX	XX XXXX	Doe, Joan Z.	WR	001	F		

THE UNDERSIGNED HEREBY: ☒ ASSIGNS OUT OF ANY COMPENSATION FROM THE STATE OF HAWAII OR ☐ CANCELS

(CHECK ONE BOX ONLY, IF "ASSIGNS")

☐ $_____ THE FIRST MONTH
AND $_____ EACH MONTH THEREAFTER

☒ PERCENT EACH MONTH 7.80 %

☐ MY NET WAGES

- EFFECTIVE WITH THE PAYROLL PERIOD THAT INCLUDES: ___ / ___ / ___ (MONTH / DAY / YEAR)
- WITH ENDING DEDUCTIONS FOR THE PAYROLL PERIOD PRIOR TO: ___ / ___ / ___ (MONTH / DAY / YEAR)
- WHEN MY COMMITMENT OF $_____ IS PAID OR UPON RECEIPT OF MY ASSIGNMENT CANCELLATION.

I CERTIFY THAT I WILL ABIDE BY THE REGULATION SET FORTH ON THE REVERSE SIDE OF THIS APPLICATION.

DATE _____ EMPLOYEE OR AUTHORIZED SIGNATURE _____

TYPE AGENT'S NAME, BRANCH, ADDRESS AND ZIP CODE HERE:

Employee's Retirement System
W/C -- Retirement Deduction

DATE _____ AUTHORIZED SIGNATURE OF ASSIGNEE _____

STATE COMPTROLLER (CENTRAL PAYROLL)

FOR AGENCY USE

DEDUCTION	AMOUNT
DUES	
LIFE INS.	
INC. PROT.	
CR. UNION	
TOTAL	

STATE ACCOUNTING FORM D-60
JULY 1, 1992 (REVISED)

For contributory plan members only. Obtain this multi-part carbon form from the College PO/AO/Designee. Complete as follows:

Department:	Enter "University of Hawai'i."
Sub-Division or School:	Enter respective college and department
Social Security No.:	Enter social security number.
Name:	Enter last name, first name and middle initial.
Type:	Enter "WR."
Agent:	Enter "001."
Plan:	Enter "F."
"The undersigned hereby:"	Check "ASSIGNS"
Check one box only, if "Assigns":	Check "PERCENT EACH MONTH" and enter 7.80
Date:	Enter signature date
Signature:	Sign
Type Agent's Name, etc.:	Enter Employee's Retirement System. W/C -- Retirement Deduction

HIGHLIGHTS OF THE HAWAII WORKERS' COMPENSATION LAW

STATE OF HAWAII
Department of Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

Rev. 2/95

This is an information brochure.
Secure full text from College PO/AO/Designee or University Office of Human Resources.

What To Do When You Are Injured

- Immediately notify your supervisor that you have been injured, will be seeking medical attention beyond basic first aid, and intend to file for workers' compensation. Obtain and submit the following forms to your Personnel Officer/Administrative Officer/Designated Worker's Compensation Coordinator). **Delays in submission of the following forms may delay payment of benefits**:
  - UH Form 79 (OHR), Report of Work-Related Injury/Illness - Section I
  - UH Form 41 (OHR), Notification and Election of Compensation for Work-Related Injury/Illness
  - State Accounting Form D-60, If you are a contributory retirement plan member

- If you have received medical attention, please inform your supervisor immediately and provide the following information:
  - If applicable, name of hospital or clinic that rendered emergency treatment
  - Name and address of your attending physician
    - You are allowed one change in attending physicians without seeking prior authorization from the Third Party Administrator of the University's workers' compensation program (TPA).
  - Have your medical providers submit billings and reports to the following TPA:

    Constitution State Service Company (CSSC)
    P.O. Box 1059
    Honolulu, HI 96808

- If you are unable to return to work, you are responsible for providing your supervisor with a certificate of disability from your attending physician for each period of disability and for notifying your supervisor of the estimated date of return to work.

- In accordance with Section 386-31, HRS, Total Disability, there is a three (3) calendar days wait period during which wage replacement benefits are not paid. You need to submit a leave request (UH Form 1, Request for Leave) to your supervisor to request sick and/or vacation leave or leave without pay (LWOP) to cover your absence from work for these days.

- If your claim is deemed compensable and you require time-off during working hours for medical treatment, submit to your PO/AO/Designee a competed UH Form 83 (OHR), Time-Off for Treatment of Work-Related Injury/Illness.

- Workers' Compensation benefits include direct payment to medical providers for all appropriate treatment. If for some reason, you incur out-of-pocket medical expenses for which you wish reimbursement, submit a request directly to the TPA with the original cash register receipt and prescription label. Consult the TPA for the specifics of filing reimbursement claims.

- You may select for treatment of your injury any physician who is practicing on the island where the injury was incurred. However, should you decide to change to another physician, you must:
  - inform your physician and the TPA, **prior to making a first change**, of your desire to change and furnish both with the name of the selected physician.
  - receive the approval of the TPA or the Director of Labor, upon application and justification, **prior to making any subsequent change** after the first change.

  Note: The TPA may also appoint a physician or its choice, for purpose of examination.

- Read the copy of the "Highlights of the Hawai'i Workers' Compensation Law" brochure provided by your PO/AO/Designee.

- Notify your PO/AO and the TPA of any change in mailing address or phone number. Failure to do so may delay receipt of benefits.

University of Hawai‘i
TIME-OFF FOR TREATMENT OF WORK-RELATED INJURY/ILLNESS

An employee returning to duty following an industrial injury who requires follow-up medical treatments shall be provided duty time off to keep such appointments which cannot be scheduled during off-duty hours. Time-off for such treatment is provided only for work-related injuries deemed compensable. Treatments must be directly related to the Worker's Compensation claim for injury/illness. This time-off includes reasonable travel time to and from the medical appointment.

Part I (Employee to Complete)

Employee: _____ Date of Injury: _____

Position Title: _____ Dept./Div.: _____

Address (Work Site): _____

Work Phone No.: _____ APPOINTMENT: DATE: _____ TIME: _____

Employee's Signature: _____ Date: _____

Part II (Supervisor to Complete) On date of appointment, Employee gives to Supervisor to have departure time entered and signed. Employee takes this form to the physician for completion of Part III. Upon his/her return to work, the Employee must give this form to the Supervisor to enter the time returned and sign.

Date & Time Left	Supervisor's Signature	Date & Time Returned	Supervisor's Signature
_____	_____	_____	_____

Part III (Medical Provider to Complete)

Medical Provider: _____ Specialty: _____

Address: _____ Phone No.: _____

Approximate Time Patient Arrived: _____ Completed Treatment at: _____

Brief Description of Treatment Provided: _____

_____

_____

_____

Date/Time of Next Scheduled Appointment: _____

Is the patient's condition stabilized and ready for permanent impairment rating? ☐ Yes ☐ No

_____ _____

Signature of Medical Provider Date

A9.720
Attachment 8

University of Hawai‘i
COMPUTATION OF AVERAGE WEEKLY WAGES FOR
TEMPORARY DISABILITY PAYMENTS

Under the provisions of Section 386-51, HRS, Computation of average weekly wages, and Rule 23, Regulation XXXIX, Department of Labor and Industrial Relations, the average weekly wage of an employee for temporary total disability (TTD) and/or temporary partial disability (TPD) payments must be computed so as to include overtime, temporary assignments and differentials during the 12-month period preceding an industrial injury. This information is not available in the University Office of Human Resources, Workers' Compensation Section, but is required to process the temporary disability payments for:

Name:_____ Date of Injury/Illness: :_____

Indicate the amounts paid to the above named employee under object symbols 2002 through 2031 as appropriate for the 12-month period preceding the date of the accident. In the case of non-regular employees and student assistants, only payments under object symbols 2102 and 2202 are to be reported. This information can be obtained from the FHMR751 Detail Payroll Feed Report by Fiscal Officer.

Please indicate only applicable symbols; indicate "none" if appropriate.

Object Symbol	Description	Amount

Had the employee earned and not been paid for any overtime, standby, or shift differentials as of the date of the accident? ___ yes ___ no If yes, what is the total amount earned, but not yet paid. $_____

Was the employee performing service on a temporary assignment at a rate of pay higher than his regular rate at the time of the injury? ___ yes ___ no

Please submit this form with the required information to the University Office of Human Resources, Workers' Compensation Section.

Prepared by: _____
Personnel Officer/Administrative Officer/Designee

_____
Phone

Workers' Compensation Industrial Injury Leave Worksheet

Employee (Last, First, MI.):_____ Date of Injury:_____

Department/College/Office:_____Contact Person:_____ Tel. No.:_____

BALANCE AT END OF PRECEDING MONTH:

Vacation Hours _____ **Sick Hours** _____

Month: _____ Date Returned to Work: _____

Date	Hrs. Related to Claim	Hrs. Worked	Hrs. Sick Leave	Hrs. Vacation Leave	Hrs. Other Paid Leave	Hrs. Leave Without Pay	Row Total Must Equal 8
1							8
2							8
3							8
4							8
5							8
6							8
7							8
8							8
9							8
10							8
11							8
12							8
13							8
14							8
15							8
Total Hrs.							

Date	Hrs. Related to Claim	Hrs. Worked	Hrs. Sick Leave	Hrs. Vacation Leave	Hrs. Other Paid Leave	Hrs. Leave Without Pay	Row Total Must Equal 8
16							8
17							8
18							8
19							8
20							8
21							8
22							8
23							8
24							8
25							8
26							8
27							8
28							8
29							8
30							8
31							8
Total Hrs.							

I certify that the above information is correct and that the required medical certificate of disability is attached.

_____ _____

Signature of Admin/Pers Officer or Designee Date

Instructions

1. Based on the employee's leave record, the employee's balance of accumulated sick/vacation leave as of the last day of the previous month must be completed at the top of the form.

2. For the entire month, type or print the number of hours attributable to each category indicated, that is, hours of industrial injury leave, hours worked, hours of sick leave, hours of vacation leave or leave-without-pay taken for each work day. The total of all categories for each work day must equal 8 hours.

3. Attach a copy of the applicable physician's certification of disability due to the employee's industrial injury for the pay period(s) for which the Worksheet is being submitted. Ensure that the dates shown on the physician's certification coincide with the dates within the pay period(s) for which the Worksheet is being submitted.

   Note: Worksheets submitted without applicable physicians' certificates may be returned and will delay the preparation of the Form 9, which may be essential for payroll processing purposes and is needed to determine the number of hours of sick/vacation leave to be charged to supplement TTD/TPD benefits, in accordance with the employee's election.

4. Based on the submitted Worksheet and the case manager's authorization for payment of TTD/TPD benefits, the requisite payment document, Form 9, State of Hawai'i Disability Worksheet, will be generated by the Office of Human Resources (OHR), and a copy of the completed Form 9 will sent to the submitting office.

5. OHR will prepare the applicable Forms 1, Request for Leave of Absence, to effect regular salary payments to supplement TTD/TPD benefits, in accordance with the employee's election and authorization. Programs are to prepare any Form 1 for absences not compensated by TTD/TPD; i.e., non-workers' compensation sick leave or vacation leave.

6. Worksheets and accompanying physicians' certifications should be submitted as soon as possible. For claimants who are on extended TTD/TPD and who are expected to continue on extended TTD/TPD, Worksheets and physician's certifications must be received by OHR at the beginning of each month no later than three (3) days prior to the first payroll deadline set by Payroll for "Changes."