Policy: Paid Absences Due to On-The-Job Injuries	**Number: 610.02**
Date Revised:	**Supersedes:**
Cross Reference: ***Alabama Community College System Policy 610.02***	**Issued: 04/10/2019**

1. System Presidents are authorized to approve payment of salaries and fringe benefits for the equivalent of up to ninety (90) working days for absences arising from on-the-job injuries to employees when the President has determined that an employee has been injured on the job and cannot return to work as a result of the injury. An on-the-job injury is defined as "any accident or injury to the employee occurring during the performance of duties or when directed or requested by the employer to be on the property of the employer which prevents the employee from working or returning to his or her job".

2. Continuation of salary and fringe benefits for the appropriate number of working days shall be consistent with the employee's injury and the subsequent absence from work resulting from the injury. This policy shall apply to temporary disability of the employee as applicable to the on-the-job injury. In no event shall the salary and fringe benefits continuation provided by this policy exceed the equivalent of 90 working days.

3. The President/designee shall require medical certification from the employee's licensed healthcare provider that the employee was injured and cannot return to work as a result of the injury. The President/designee may, within his/her discretion, require a second opinion from another licensed healthcare provider at the expense of the institution. The President/designee may require a statement from the licensed healthcare provider that there is a reasonable expectation that the employee will be able to return to work and the time frame for such return.

4. Accrued leave shall not be deducted from the employee's account if absence from work results from an on-the-job injury, unless the absence exceeds the authorized amount granted under Section 1 and the employee requests such leave.

5. The President/designee shall inform in writing the employee who is injured on the job of the employee's rights to appear before the State Board of Adjustment and to claim unreimbursed medical expenses and costs through the State Board of Adjustment and shall inform the injured employee regarding applicable ACCS Board of Trustees policies. Such notification shall be made within thirty (30) calendar days of notice of the injury.

6. Eligibility for salary and benefits under this policy is contingent upon proper notification by the injured employee to the President within twenty-four (24) hours after the occurrence of the injury. In no event will this policy be utilized if notification is not made by the employee or the employee's representative within five (5) work days of the injury.

7. External contractors, consultants, work-study students, and interns are not employees for the purposes of this policy.

APPLICATION FOR SALARY CONTINUATION FOR ABSENCE DUE TO JOB-RELATED INJURY

This form should be completed by the injured employee or in the event the employee is not clinically able to complete and submit this application, by a representative of the employee. Such individual must be reasonably knowledgeable concerning the injury and the condition of the employee.

Name of Injured Employee: _____

Social Security Number: _____

Title or Position of Employee:_____

Specific Location at Which Injury Occurred: _____

Date and Time of Injury:_____

Name of Witnesses to the Injury: (NOTE: If there were no witnesses to the injury, the employee must have their statement notarized below.)

_____

_____

State in detail how your injury occurred: _____

_____

_____

State all factors which contributed to your injury: _____

_____

_____

Describe the nature and extent of your injury:_____

_____

_____ _____

Signature of Employee Date

STATE OF _____, COUNTY OF _____

BEFORE ME, the undersigned Notary Public, personally appeared _____, who is known to me, and being duly sworn, conformed on the _____ day of _____, 20____that the information contained hereinabove is true, accurate, and complete the best of his/her knowledge and information.

Signature of Notary Public _____

My Commission Expires _____

PHYSICIAN'S STATEMENT

(Necessary if employee is requesting payment for an absence of more than three (3) working days or if the injury arising from job-related stress)

Diagnosis: _____

_____

_____

_____

_____

Treatment: _____

_____

_____

_____

_____

Prognosis: _____

_____

_____

_____

_____

Estimated Date for Return to Work: _____

_____ _____

Signature of Physician Date

Office Address of Physician: _____

_____

Telephone: _____