ARKANSAS WORKFORCE CENTERS
Bringing People and Jobs Together.SM

Worksite Agreement

The following Agreement between White River Planning and Development, Inc. as the WIOA Administrative Entity and _____as the "Worksite" is entered into for the purpose of providing Work Experience training in accordance with the Workforce Innovation and Opportunity Act (WIOA) and any subsequent amendments and the terms and conditions of this agreement herein referred to as the "Training Site."

Training Site Address: _____Phone No._____

Contact Person _____ Title _____

TERM: This agreement will take effective on _____ and terminate no later than _____. Total training hours **will not exceed 40 hours per week** during agreement period. The participant will be paid $_____ per hour on the dates reflected on the attached pay schedule.

PURPOSE: Work experiences are designed to enable participants to gain exposure to the working world and its requirements. The experience should help participants acquire the personal attributes, knowledge and skills needed to obtain a job and advance in employment. It also provides participants with the opportunities for career exploration and skill development.

WORKSITE RESPONSIBILITIES AND STANDARDS

1. Provide sufficient work for WIOA participants in accordance with the worksite agreement during work hours.
2. Explain the participant's job duties and responsibilities.
3. Provide qualified direct supervision to participants at all times during work hours, not to exceed 12 participants per supervisor and objectively evaluate the participant.
4. Insure that the participants do not exceed authorized working hours (maximum 40 hours per week) as stated in this Agreement.
5. Insure the conditions of work are safe and the participant works in a safe manner and in compliance with the DOL Child Labor Laws.
6. Insure the participant's work time sheet is accurate and reflects only the actual hours worked. Work hours are to be written only after the participant completes each day's work. Supervisor and participant should sign the time sheet at the end of the workday on the last day of each pay period. No more than 40 hours a week will be paid.
7. Talk through minor job-related problems with the participant.
8. Contact WIOA staff to assist participants with personal problems or recurring work-related problems, i.e. excessive absenteeism, poor job performance, etc.
9. Guarantee that the participant will work only at the worksite address(es) listed on the worksite agreement (no private property).
10. Provide sufficient equipment and/or material necessary for assigned tasks.
11. Report job-related accidents and injuries to the Career Specialist immediately.
12. Agree to instruct and counsel participants concerning safety procedures, as it relates to his/her work assignment.
13. Insure that participants are free of any direct or indirect discrimination based on race, color, national origin, age, sex, religion, handicap, political affiliation or belief, or citizenship.
14. Insure compliance with Federal/State/WIOA/OSHA Regulations, WIOA Policies and Procedures, and the worksite agreement.
15. Insure that participants are not involved in or work on sectarian related activities.
16. Insure that participants are not assigned to this worksite if this will result in the displacement of already employed workers or impair existing contracts
17. Assure WIOA participants are not utilized in any service/duties whereby they are in a physically harmful environment.
18. Worksite officials hereby acknowledge that any litigation that may arise as a result of a participant being at this worksite is the sole responsibility of the worksite.

19. Any participant's unauthorized usage of telephones or other equipment/facilities is sole responsibility of the worksite.
20. Participants are prohibited from operating their own vehicle or company's vehicle for the purpose of running errands, transporting, or other usage during work hours.
21. Participants are not permitted to accompany groups/individuals on trips if signed "in" on WIOA time sheets.

CAREER SPECIALIST RESPONSIBILITIES

1. Develop an employment plan with the participant, based on an evaluation of the educational and work-related goals. The employment plan should directly correlate with the provided work experience opportunity.
2. Assess and identify any initial supportive services, educational needs, stipends and/or incentives anticipated throughout the work experience and incorporate those activities into the employment plan.
3. Link academic and occupational learning as part of the menu of services for youth work experiences.
4. Provide access to the 14 WIOA program elements for youth, when applicable.
5. Counsel participants in areas of career and personal development.
6. Insure that participants are not related to supervisor.
7. Provide worksite and participant orientations for the worksite supervisor and work experience participant that describes and explains the expectations of the work experience opportunity.
8. Assist worksite supervisor and participant in filling out any and all documentation needed.
9. Maintain regular contact with the worksite supervisors and the participant, in order to provide necessary counseling and address the needs of all parties.
10. Review the completed timesheets for accuracy and consistency for all authorized hours worked.
11. Provide a payroll schedule to participant and worksite supervisor.
12. Insure that the worksite is working in accordance with Federal/State/WIOA regulations and WIOA Policies/Procedures and DOL Child Labor Laws.
13. Monitor participant's job performance.
14. Visit worksite to see that participant is working in accordance with Worksite Agreement (hours, job duties, etc.).
15. Insure that time sheets are completed accurately, and the appropriate validated signatures are affixed.
16. Insure that time sheets are submitted in accordance with payroll schedule.
17. Insure that participants are paid in accordance with the payroll schedule.
18. Notify worksite supervisor and participant of any problems or circumstances that could potentially lead to an early termination of the agreement. In addition, provide notification of any intent to terminate this agreement earlier than what is outlined in this agreement.
19. Resolve disciplinary and grievance problems.
20. Process Workman's Compensation claims in a timely manner.
21. Continuously monitor and evaluate worksite to ensure safety, appropriateness and performance of the worksite and participant.

PARTICIPANT RESPONSIBILITIES

1. Develop an employment plan with a career specialist, based on an evaluation of the educational and work-related goals. The employment plan should directly correlate with the provided work experience opportunity.
2. Attend a participation orientation that describes and explains the expectations of the work experience opportunity.
3. Put forth his/her best efforts to acquire all necessary skills and to fulfill all work requirements.
4. Keep track of, respect and observe the policies, rules and work hours provided.
5. Report the actual hours worked on the provided timesheet. (Overtime, holiday pay or sick time cannot be authorized or accrued)
6. Attend all job interviews and/or workshops arranged by your career specialist, even if scheduled during the time in which you are on the work experience site.
7. Communicate with your supervisor and career specialist regarding site progress, problems, tardiness, absences, or any time away from the work site.
8. Notify your career specialist immediately if there are concerns regarding the work experience placement. If there are problems that are unable to be worked out with the supervisor, contact the workforce center representative immediately.
9. Secure reliable transportation to and from the worksite, including access to child care, when applicable.
10. Immediately report any personal work accidents or injuries to the worksite supervisor and workforce center representative.
11. Attend any assigned workshops or further education classes as assigned.

Termination: If a participant is not performing satisfactorily, the supervisor must contact WIOA staff to discuss the problem. A supervisor cannot terminate a participant from the Work Experience Program. If the situation warrants, the supervisor must refer the participant to Workforce Development Board of North Central Arkansas staff immediately. The Workforce Development Board of

North Central Arkansas staff will work with the worksite supervisor to ensure the problems will be resolved in a reasonable and mutually satisfactory manner.

Please remember that the participant under your supervision must be assured of equal, fair, and just treatment under the Civil Rights Act. The WIOA Work Experience Program is required to assure each participant of his/her grievance procedures.

Monitoring: Monitoring visits will be made to your worksite. Monitors will talk to you and to participants about the program and you will be asked to complete survey questionnaires. You will be notified if any deficiencies are found. Where problems persist, WIOA reserves the right to discontinue use of the worksite.

Work Experience Agreement
Youth work experiences must include academic and occupational components. The occupational component refers to contextual learning that accompanies a work experience (for example learning about the duties of occupations). The academic component may include workforce preparation activities (pre-employment skills training), basic academic skills, and/or hands-on occupations skills training connected to a specific occupation, occupational cluster, or career pathway. Describe how these components are being met:

Occupational:

_____

_____

_____

_____

Academic:

_____

_____

_____

_____

Comments: _____

_____

I, _____, certify that I have read, do understand and have received a copy of the Worksite Agreement. (*Name of person responsible for worksite*)

_____	_____
Name of Worksite	Career Specialist
_____	_____
Signature	Signature
_____	*Career Specialist*
Title	Title
_____	_____
Date	Date

I have received the worksite supervisor orientation for the Work Experience/Summer Employment Program. I have had the Federal and State Regulations, Department of Labor Laws and WIOA local policies explained to me. I agree to comply with these rules and regulations.

Worksite Supervisor Signature	**Print Name**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Days of Work: _____ Hours of Work: _____

Lunch Time: _____ # Participants Assigned: _____

By my signature, I agree to and will be expected to perform the conditions outlined in this agreement.

Participant(s) Name:	Participant(s) Signature:	Age	Sex	Race	Other Info
_____	_____	___	___	____	_____
_____	_____	___	___	____	_____
_____	_____	___	___	____	_____
_____	_____	___	___	____	_____
_____	_____	___	___	____	_____

Worksite Agreement Approved by:

_____
(Program Manager or Records Manager Signature)

Worksite Safety Training

Participant Name: _____

Supervisor name: _____

Worksite: _____

I, _____ (print name) have instructed the above named participant in safety procedures at our workplace.

List safety topics covered below:

_____

_____

_____

_____

_____

_____

Supervisor or Safety Trainer signature **Date**

_____

Participant signature **Date**

***** <u>THIS SAFETY FORM IS REQUIRED FOR EACH PARTICIPANT</u> *****

Please make a copy for your WIOA file and return original to Career Specialist

The next three pages are required to be posted in a conspicuous place where participant can easily find.

Please advise participant of location.

Equal Opportunity is the Law

It is against the law for this recipient of federal financial assistance to discriminate on the following basis:

- Against any individual in the United States, on the basis of race, color, religion, sex, national origin, age, disability, political affiliation or belief and;
- Against any beneficiary of programs financially assisted under Title I of the Workforce Innovation and Opportunity Act (WIOA), on the basis of the beneficiary's Citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his or her participation in any WIOA Title I-financially assisted program or activity.

The recipient must not discriminate in any of the following areas:

- Deciding who will be admitted, or have access, to any WIOA Title I-financially assisted program or activity;
- Providing opportunities in, or treating any person with regard to, such a program or activity; or
- Making employment decisions in the administration of, or in connection with, such a program or activity.

What to do if you believe you have experienced discrimination

If you think that you have been subjected to discrimination under a WIOA Title I financially assisted program or activity, you may file a complaint within 180 days from the date of the alleged violation with either:

- The recipient's Equal Opportunity Officer (or the person whom the recipient has designated for this purpose); or
- The Director, Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210.

If you file your complaint with the recipient, you must wait either until the recipient issues a written notice of Final Action, or until 90 days have passed (whichever is sooner), before filing with the Civil Rights Center (CRC), U.S. Department of Labor, 200 Constitution Avenue NW, Room N-4123, Washington, DC 20210.

If the recipient does not give you a written Notice of Final Action within 90 days of the day on which you filed your complaint, you do not have to wait for the recipient to issue that Notice before filing a complaint with CRC. However, you must file your CRC Complaint within 30 days of the 90-day deadline (in other words, within 120 days after the day on which you filed your complaint with the recipient.)

If the recipient does give you a written Notice of Final Action in your complaint, but you are dissatisfied with the decision or resolution, you may file a complaint with CRC. You must file your CRC complaint within 30 days of the date on which you received the Notice of Final Action.

Local Level
Lee Hissong
White River Planning & Development
P.O. Box 2396,
Batesville, AR 72503
Telephone: (870) 793-5233

State Level
Gloria Johnson
Employment Security Department
Equal Opportunity Officer
P.O. Box 2981
Little Rock, AR 72203
Telephone: (501) 682-3106
ARS: 1-800 285-1131

Federal Level
Director
CRC Center
U.S. Department of Labor
200 Constitution Avenue N.W.
Room N-4123
Washington, D.C. 20210
(202) 693-6500

Form AR-P	ARKANSAS WORKERS' COMPENSATION COMMISSION	P
Ark. Code. Ann. §11-9-403, 407 AWCC Rule 7 Updated 6-16-14	324 Spring Street, Little Rock, AR 72201 Mail: P.O. Box 950, Little Rock, AR 72203-0950 Little Rock Office – 1-800-622-4472 / 501-682-3930 Springdale Office – 1-800-852-5376 / 479-751-2790	

WORKERS' COMPENSATION INSTRUCTIONS TO EMPLOYERS & EMPLOYEES

All employees of this establishment entitled to benefits under the provisions of the Arkansas workers' compensation laws are hereby notified that their employer has secured the payment of such compensation as may at any time be due employees or their dependents. This employer is required by state law to provide workers' compensation coverage or this employer has waived the exclusion or exemption from the operation of the workers' compensation laws, and the employer certifies by the display of this poster that workers' compensation coverage is now provided by a workers' compensation insurance policy or by enrollment in the Arkansas Self-Insurance Program or by the Public Employee Claims Division of the Arkansas Insurance Department.

EMPLOYER—Name: WHITE RIVER PLANNING & DEVELOPMENT DISTRICT

CARRIER—Name: THE TRAVELERS INSURANCE COMPANIES

Address: P.O. BOX 660456
DALLAS, TX 75266-0456

Telephone No. (800) 238-6225

POLICY NUMBER: 8H361962 **EXPIRATION DATE:** 10-06-19

IN CASE OF JOB-RELATED INJURIES OR OCCUPATIONAL DISEASES

The Employer Shall:

1. Provide all necessary medical, surgical and hospital treatment, as required by law, following the injury and for such additional time as ordered by the Workers' Compensation Commission.
2. Provide compensation payments in accordance with the provisions of the law. The first installment of compensation becomes due on the 15th day after the employer has notice of the injury or death, except in those cases where liability has been denied by the employer.
3. Provide prompt reporting of accidents to appropriate parties.
4. Keep a record of all injuries received by their employees.

The Employee Shall:

The employee shall report the injury to the employer on Form N and to a person or at a place specified by the employer, unless the injury either renders the employee physically or mentally unable to do so, or the injury is made known to the employer immediately after it occurs. The employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's notice of injury. All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements. The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

Failure to give such notice shall not bar any claim (1) if the employer had knowledge of the injury or death, (2) if the employee had no knowledge that the condition or disease arose out of and in the course of employment, or (3) if the Commission excuses such failure on the ground s that for some satisfactory rea son such notice could not be given. Objection to failure to give notice must be made at or before the first hearing on the claim.

Statutory Information:

Ark. Code Ann. §11-9-514(b) states: "Treatme nt or services furnished or prescribed by any physician other than the ones selected according to the foregoing, except emergency treatment, shall be at the claimant's expense."

Ark. Code Ann. § 11-9-514(f), however, indicates: When compensability is controverted, subsection (b) shall not apply if:

(1) The employee requests medical assistance in writing prior to seeking the same as a result of an alleged compensable injury; and

(2) The employer refuses to refer the employee to a medical provider within forty-eight (48) hours after such written request as provided above; and

(3) The alleged injury is later found to be a compensable injury; and

(4) The employer has not made a previous offer of medical treatment.

If you have any questions regarding your rights under the Arkansas workers' compensation laws, you may call an Arkansas Workers' Compensation Commission legal advisor at our toll-free number listed above.

All employers who come within the operation of the Arkansas workers' compensation laws and have complied with its provisions must post this notice in a **CONSPICUOUS** place in or about their place or places of business.

AWCC Form P

(Posting Notice)

A Posting Notice is mentioned in **Ark. Code Ann. §11-9-403, Ark. Code Ann. §11-9-407** and **AWCC Rule 7. AWCC Form P** satisfies all requirements.

Form P.

1. Is to be on display in a conspicuous place;
2. Tells employers what to do when an employee is injured.
3. Instructs employees to notify the employer immediately (or no later than the close of the next business day) when injured;
4. Lists the claims office that will be handling the insurance aspects of the case;
5. Gives the claims office telephone number;
6. Announces the expiration date of the insurance policy; and
7. Provides telephone numbers for Arkansas Workers' Compensation Commission legal advisors if either party needs assistance.

Employers without **Form P** may lose the use of **Form N** as a defense in litigation. Employees disobeying instructions on **Form P** may delay their benefits or jeopardize the awarding of any benefits in a contested case.

The AWCC furnishes samples, not supplies, of **Form P.** Carriers are to send their insureds an adequate number, and self-insureds must arrange with a printer for the supply they need. Carriers and employers may enlarge **Form P** for posting purposes.

Information about **FORM P** is available from the Support Services Division (1-800-622-4472 or 501-682-3930) .

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or concels any material information, or who willfully and knowingly employs any device, scheme, or actifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under ... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

Form AR-N	ARKANSAS WORKERS' COMPENSATION COMMISSION	N
Ark. Code Ann. §§11-9-701, 508, 514 AWCC Rule 33 Revised: 1-1-2001	324 Spring Street, Little Rock, AR 72201 Mail: P. O. Box 950, Little Rock, AR 72203-0950 501-682-3930 / 1-800-622-4472	

EMPLOYEE'S NOTICE OF INJURY

EMPLOYEE INFORMATION (Please Print in Ink)

Employee's Last Name	First Name	M I	Social Security Number	Home Phone No.

Street Address or P.O. Box	City	State	Zip Code

EMPLOYER INFORMATION (Please Print)

Employer's Name	Supervisor's Name

Employer's Street Address or P.O. Box	Employer's City	State	Zip Code

ACCIDENT INFORMATION (Please Print)

Place of Accident	Date of Accident	Time of Accident	Date /Time Employer Notified of Accident

What part of your body was injured? _____

Briefly discuss the cause of injury: _____

WITNESSES

Name and address of witness(es), if any: _____

I hereby authorize any hospital, physician, psychotherapist or practitioner of the healing arts to furnish the bearer any information, written or oral, including, but not limited to, copies of medical records concerning my past, present or future physical, mental or emotional condition. I hereby waive my physician- and psychotherapist-patient privilege. A photostatic copy of this authorization shall be as effective and valid as the original. My signature below also indicates that I have been provided with my rights regarding change-of-physician. (See additional information on back side of form)

Date_____ Signature _____

Assistance with AWCC Form N is available from the AWCC Legal Advisor Division (1-800-250-2511 or 501-682-3930). Information is supplied by the Support Services Division (1-800-622-4472 or 501-682-3930).

Ark. Code Ann §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

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EMPLOYEE'S NOTICE OF INJURY

NOTICE TO EMPLOYEE - Fill out this form to give to your employer immediately.

Ark. Code Ann. § 11-9-701. Notice of injury or death.

(a)(1) Unless an injury either renders the employee physically or mentally unable to do so, or is made known to the employer immediately after it occurs, the employee shall report the injury to the employer on a form prescribed or approved by the Workers' Compensation Commission and to a person or at a place specified by the employer, and the employer shall not be responsible for disability, medical, or other benefits prior to receipt of the employee's report of injury.

(2) All reporting procedures specified by the employer must be reasonable and shall afford each employee reasonable notice of the reporting requirements.

(3) The foregoing shall not apply when an employee requires emergency medical treatment outside the employer's normal business hours; however, in that event, the employee shall cause a report of the injury to be made to the employer on the employer's next regular business day.

(b)(1) Failure to give the notice shall not bar any claim:
(A) If the employer had knowledge of the injury or death;
(B) If the employee had no knowledge that the condition or disease arose out of and in the course of the employment; or
(C) If the commission excuses the failure on the grounds that for some satisfactory reason the notice could not be given.

(2) Objection to failure to give notice must be made at or before the first hearing on the claim.

CHOICE/CHANGE OF PHYSICIAN

Rights and responsibilities. Treatment or services furnished or prescribed by any physician other than the ones selected according to the provisions below, except emergency treatment, shall be at the claimant's/employee's expense.

Ark. Code Ann. § 11-9-508. Medical services and supplies.

"(e). . . [T]he injured employee shall have direct access to any optometric or ophthalmologic medical service provider who agrees to provide services under the rules, terms, and conditions regarding services performed by the managed care entity initially chosen by the employer for the treatment and management of eye injuries or conditions."

1. Your employer shall have the right to select the initial primary care physician from among those associated with certified MCOs.

2. You may request a change-of-physician. You should initially request a change from the insurance carrier or employer. Within five business days of your initial request for a change-of-physician, the insurance carrier or employer should notify you of its decision to grant or deny the change-of-physician.

3. If your request for change of physician is denied you may send a petition to the Clerk of the Arkansas Workers' Compensation Commission for a one (1) time only change-of-physician.

4. **If your employer has contracted with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must also either be associated with the certified MCO chosen by your employer or who is your regular treating physician. (Your "regular treating physician" is one who maintains your medical records and with whom you have a history of regular treatment before the onset of your compensable injury.) The health care provider to whom you change must agree to refer you to the certified MCO chosen by your employer for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by the MCO initially chosen by your employer.

5. **If your employer does not have a contract with a certified MCO,** you shall be allowed to change physicians by petitioning the commission one (1) time only for a change-of-physician to a physician who must either be associated with any certified MCO or who is your regular treating physician. (See definition above.) The health care provider to whom you change must agree to refer you to a physician associated with any certified MCO for any specialized treatment, including physical therapy, and must agree to comply with all the rules, terms, and conditions regarding services performed by any certified MCO.

Back side / Two-sided form

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	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 TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED ☐ AM ☐ 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? ☐ YES ☐ 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? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

AWCC Form 1
(Employer's First Report of Injury or Illness)

Ark. Code Ann. § 11-9-529 allows employers 10 days to report injuries. Those involving either more than 7 days of lost time or indemnity payments require **Form 1**. Also, a Form 1 is required for all controversions including a medical-only case. Self-insured employers file **Form 1** with the AWCC; other employers send it to their insurance representatives.

Employers do **NOT** fill in the shaded areas.

On **Form 1**, employers/carriers must:

1. In the **Occurrence Section** list the date the employer first knew of the injury. The 10 days to report begin either on the date of disability **or** the date the employer was notified, whichever date is later.

2. Give the name of the carrier. An insurance agency or third party administrator should be listed in the **Preparer's Section**. A carrier can pre-print its name and address in the **Carrier Section** to help clients properly report.

3. Specify the carrier Federal Employer Identification Number (FEIN) in the **Carrier Section**.

4. Type or print in ink. An illegible, incomplete **Form 1** will be returned.

Neglect of **Form 1**: Late employee benefits, exposing employers to fines.

Lack of **Form 1**: Delays in insurance investigation.

General inquiries on Form 1 can be answered by the AWCC Support Services Division. Questions on a specific Form 1 may be directed to the Research and Statistics Section, which processes the accident reports. (1-800-622-4472 or 501-682-3930).

Ark. Code Ann. §11-9-106(a): "Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme, or artifice for the purpose of: obtaining any benefit or payment; defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment; or obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter shall be guilty of a Class D felony. Fifty percent (50%) of any criminal fine imposed and collected under .... this section shall be paid and allocated in accordance with applicable law to the Death and Permanent Total Disability Trust Fund administered by the Workers' Compensation Commission."

(Revised 1-1-2001)

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.

WIOA TIME SHEET

WRPDD P.O. BOX 2396 BATESVILLE, AR 72503
PHONE: 870-793-5233 FAX: 870-600-4030
WIOAPAYROLL@WRPDD.ORG

NAME:_____

WORKSITE NAME:_____ WORKSITE PHONE: _____

MONTH:_____ YEAR:_____

Please retain a copy for your records. Fax or email copy and mail original to the address listed above.

Record time in 15 minute increments

Chart of 15 minute increments: 00-07=00; 08-22=15; 23-37=30; 38-52=45; 53-59=00

Please write legibly with blue or black ink and do not use white-out. If a mistake is made, draw a single line through it and initial the corrected information.

Please use a separate time sheet for each payroll period. (1st through the 15th and 16th through the end of the month)

Date	BEGINNING TIME	LUNCH BREAK BEGIN	LUNCH BREAK END	ENDING TIME	TOTAL TIME
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
	:	:	:	:	
				TOTAL HOURS*	

*

When recording **total time** worked, remember to convert partial hours to decimals to add totals properly.
15 minutes = .25, 30 minutes = .50, 45 minutes = .75.

I CERTIFY THAT I HAVE WORKED THE HOURS REPORTED ABOVE

PARTICIPANT SIGNATURE:_____

I CERTIFY THAT THIS PARTICIPANT HAS WORKED AS REPORTED ABOVE

SUPERVISOR SIGNATURE:_____

Please obtain both signatures and submit no later than the morning of the next business day after payroll period end.

Internal Use Only:

PROGRAM CODE:_____ CHECKED BY:_____

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.

Work Opportunity Tax Credit

What is WOTC?

The Work Opportunity Tax Credit (WOTC) is a Federal tax credit available to employers for hiring veterans, SSI Recipients, Qualified Long-term Unemployment Recipients, Ex-Felons and other individuals from certain "target groups" who have consistently faced significant barriers to employment. WOTC joins other workforce programs that incentivize workplace diversity and facilitate access to good jobs for American workers.

What does WOTC do?

WOTC helps targeted workers move from economic dependency into self-sufficiency as they earn a steady income and become contributing taxpayers, while participating employers are able to reduce their income tax liability.

How large is the tax credit?

The maximum tax credit ranges from $1,200 to $9,600, depending on the employee hired.

How are WOTC credits determined?

- WOTC questionnaires are completed as part of employee on-boarding
- Data is then evaluated and submitted to state workforce agencies by on behalf of the client to obtain the maximum possible tax credits.

How can ETC help me with WOTC's?

You might be able to receive a tax credit when you hire an employee from a "target group" ETC can help track and monitor this for you to ensure that you receive your tax credit.

WIOA Timesheets

Email to: wioapayroll@wrpdd.org
Or
Fax to: 870-600-4030

****All Signatures are required before submitting timesheets**

****Timesheets are due in by 10:00 am on the following dates for 2019:**

Jan 02	Jan 16
Feb 01	Feb 19
March 01	March 18
April 01	April 16
May 01	May 16
June 03	June17
July 01	July 16
Aug 01	Aug 16
Sept 03	Sept 16
Oct 01	Oct 16
Nov 01	Nov 18
Dec 02	Dec 16

If you have questions, please contact your Career Specialist @ 870-307-6805 or 870-793-5233