

RESOLUTION RELATED TO THE ALABAMA PUBLIC EDUCATION EMPLOYEE INJURY COMPENSATION PROGRAM

WHEREAS, the Alabama Legislature passed into law *Act 2025-223*, which creates the Public Education Employee Injury Compensation Program; and

WHEREAS, said Act also requires the State Board of Education to adopt a uniform physician certification form and a local education agency reimbursement to employer form to be used as required in connection with said Act:

NOW, THEREFORE, BE IT RESOLVED, That the Alabama State Board of Education does hereby adopt the attached forms to be used as required in connection with Alabama Act 2025-223.

Done this 8th day of October 2026

PHYSICIAN CERTIFICATION FORM

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Name of Injured Employee (PLEASE PRINT) _____ (Last) _____ (First) (MI)	Date of Injury ____ / ____ / ____ Time of Injury _____	Date of Birth ____ / ____ / ____ Sex: M F	Home Phone: _____ Cell Phone: _____ Work Phone: _____	
Home Address: _____	School: Did the injury occur on school grounds? ____ Yes ____ No		Job Title _____	Job Status __ Full Time __ Part Time/Sub __ Contract
Describe how the injury occurred and specify the body parts affected: _____ _____			Employee Signature _____ Date: _____	

THIS SECTION TO BE COMPLETED BY PHYSICIAN:

Attending Physician (Please Print) _____	Medical Facility _____ Address: _____ Telephone: _____		
Employee's Date of Injury ____ / ____ / ____	Today's Date ____ / ____ / ____	____ This is patient's 1 st visit for this injury ____ This is a follow up visit due to this injury	
Please provide a DETAILED diagnosis: _____ _____		Please provide the treatment plan: _____ _____	
Is there a reasonable expectation that the employee should be able to return to work? ____ YES ____ NO If YES, date the employee can return to work: ____ / ____ / ____ If NO, please explain why not: _____ _____ Will the employee have any restrictions when returning to work? ____ YES ____ NO If YES, please explain restrictions: _____ _____ Is the employee being referred to another physician for follow up treatment or physical therapy at this time? YES or NO Signature of Physician: _____ Date: _____			

1. Employing Agency	2. Agency Address (Number and Street) (City or Town) (State) (Zip)		
3.			
<u>Name of Injured Employee</u>	<u>Social Security Number</u>	<u>Job Title</u>	
4. Number of Days Employee(s) Absent	5. Cost		
6.			
_____ Signature of Superintendent		_____ Date	

Act 2025-223 - "Any reasonable on-the-job injury costs incurred by the employer to hire a substitute per absent injured employee in a fiscal year shall be reimbursed to the employer by the state during the next succeeding fiscal year upon application by the employer to the appropriate State Board of Education department on a form adopted by the state board, not to exceed 90 working days. The department shall subsequently submit the request to the Legislature as a line-item in its budget request for reimbursement to the employer, and, if approved by the Legislature, shall reimburse the employer at the amount per day for sick leave authorized and funded in the annual budget act for public schools and colleges."

Please return this form to: ALSDE Finance (Re: Workers Compensation Reimbursement)
Alabama State Department of Education
Gordon Persons Building, Room 5301
50 North Ripley Street
Montgomery, Alabama 36130