Employee Accident Form

EMPLOYEE NAME	I.D.	TIME OF INJURY	DATE OF INJURY	FILE NUMBER

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN AND HIS/HER ADDRESS FOR THE PAST TEN YEARS

PLEASE LIST YOUR CURRENT MEDICATIONS

BRIEFLY DESCRIBE HOW YOU GOT HURT AND WHEN THE INJURY OR ILLNESS OCCURRED.

WHAT PART(S) OF THE BODY WERE HURT; AND IN WHAT PART(S) OF THE BODY DO YOU CURRENTLY FEEL PAIN?

HAVE YOU HAD TREATMENT IN THE PAST FOR THE SAME OR SIMILAR MEDICAL CONDITION?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE TREATING PHYSICIAN(S) FOR THIS CONDITION. LIST ANY MEDICATIONS YOU ARE OR WERE TAKING FOR THIS CONDITION/INJURY?

HAVE YOU BEEN TREATED IN THE PAST BY A CHIROPRACTOR?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE CHIROPRACTOR(S).

HAVE YOU FILED ANY WORKERS' COMPENSATION CLAIM(S) IN THE PAST FOR THIS MEDICAL CONDITION?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE DETAILS OF THE PREVIOUS CLAIM(S).

HAVE YOU EVER BEEN INVOLVED IN ANY MOTOR VEHICLE COLLISIONS?

☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE DETAILS OF THE CRASH, DATE, AND THE NATURE OF THE INJURY AND TREATMENT.

ARE YOU CURRENTLY ENGAGED IN ANY OTHER EMPLOYMENT OR HAVE YOU EVER BEEN ENGAGED IN ANY OTHER EMPLOYMENT WHILE YOU WERE EMPLOYED BY US?

☐ YES ☐ NO

IF YES, PLEASE LIST THE NAMES AND ADDRESSES OF THESE EMPLOYERS.

DO YOU CURRENTLY (IN THE PAST 12 MONTHS) PARTICIPATE IN ANY ATHLETIC, RECREATIONAL OR SPORTING ACTIVITIES?

☐ YES ☐ NO

IF YES, PLEASE LIST THE ACTIVITIES YOU PARTICIPATE IN.

TO WHOM DID YOU FIRST REPORT THE INJURY TO AND WHEN?

WERE THERE ANY WITNESSES TO YOUR INJURY? IF SO, WHO?

HAVE YOU EVER RECEIVED PAIN MANAGEMENT TREATMENT? IF SO, BY WHOM?

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

EMPLOYEE SIGNATURE	SUPERVISOR'S SIGNATURE AND I.D.	DATE

Great Meadows Regional School District

*Please check appropriate location:

☐ Great Meadows Middle School 273 Route 46 ☐ Central School 281 Route 46 ☐ Liberty School 334 Mt Lake Road

Bernice Biffings | Human Resources Officer
Administrator Office: 908-637-8674 Ext. 240
Email: bbiffings@gmrsd.com

EMPLOYEE WORKERS' COMPENSATION INCIDENT REPORTING FORM

***DATE OF INCIDENT: _____ ***TIME OF INCIDENT: _____ ***REPORT DATE: _____

HOW REPORTED: ☐ IN PERSON ☐ PHONE ☐ OTHER

EMPLOYEE INFORMATION:

NAME: _____

ADDRESS: _____

PHONE #: _____

DOB: _____ SEX: M ☐ F ☐

SCHOOL: _____ OCCUPATION/TITLE: _____

EXACT LOCATION OF INCIDENT: _____

_____

DESCRIPTION OF INJURY/CAUSE: _____

_____

_____

BODY PART: _____

WITNESS: _____
(NAME) (ADDRESS) (PHONE#)

TREATMENT OF INJURY BY: ☐ SCHOOL NURSE ONLY ☐ DOCTOR/HOSPITAL/MEDI-CENTER ☐ NONE

TREATMENT GIVEN ON-SITE: _____

_____

REPORTED TO WORKERS' COMPENSATION CARRIER: YES ☐ NO ☐

COMPLETED BY (print or type): _____ TITLE: _____

SIGNATURE: _____ DATE: _____

ADMINISTRATOR SIGNATURE: _____ DATE: _____

Great Meadows Regional School District

***Please check appropriate location:**

D Great Meadows Middle School 273 Route 46 D Central School 281 Route 46 D Liberty School 334 Mt Lake Road

Bernice Billings | Human Resources Officer
Administrator Office: 908-637-8674 Ext 240
Email: bbillings@gmrsd.com

NOTICE

On August 14, 1998, the Governor enacted P.L. 1998, Chapter 74 which amends the New Jersey Workers' Compensation statute. P.L. 1998, Chapter 74 provides that a person who purposely and knowingly makes false or misleading statements for the purpose of wrongfully obtaining Workers' Compensation benefits will be guilty of a crime of the fourth degree. Pursuant to N.J.S.A 2C:43-3b(2), crimes of the fourth degree are punishable by imprisonment for up to 18 months and fines of $10,000.

P.L.1 998, Chapter 74 also creates civil liability for all damages, costs and attorney's fees payable to the injured party attributable to wrongfully obtained benefits. This would require employees who have made such statements and improperly received benefits to repay the benefits to his/her employer or its insurance carrier with simple interest.

P.L. 1998, Chapter 74 further permits the Division of Workers' Compensation to order the termination and complete forfeiture of Workers' Compensation benefits for employees found to have committed a violation.

THIS FORM MUST BE SIGNED AND RETURNED

Employee Signature

_____

Date

Great Meadows Regional School District

***Please check appropriate location:**

D **Great Meadows Middle School** 273 **Route** 46 D **Central School** 281 **Route** 46 D **Liberty School** 334 **Mt Lake Road**

Bernice Billings | Human Resources Officer Administrator
Office: 908-637-8674 Ext. 240 Email:
bbillings@gmrsd.com

New Jersey Schools Insurance Group

WORKERS' COMPENSATION ACCIDENT REPORTING GUIDELINES

If an employee is injured and requires non-emergency medical treatment, a call is to be placed to Qual-Lynx at 1-800-425-3222.

By signing below, I am confirming to you that I am refusing to notify Qual-Lynx for the injury sustained at Great Meadows Regional School District at this time. If this condition continues or worsens, I agree to call Qual-Lynx at 1- 800-425-3222.

Date of Injury: _____

_____

(Print Name)

_____

(Signature) (Date)

NEW JERSEY SCHOOLS INSURANCE GROUP
6000 Midlantic Drive, Suite 300 North
Mt Laurel, NJ 08054
(609) 386-6060 FAX (609) 386-8877

MEDICAL AND/OR HOSPITAL AUTHORIZATION

RE: PATIENT
CLAIM#

TO WHOM IT MAY CONCERN

I HEREBY AUTHORIZE ANY AND ALL DOCTORS, HOSPITALS OR OTHER MEDICAL PROVIDERS TO RELEASE TO NEW JERSEY SCHOOLS INSURANCE GROUP OR ITS REPRESENTATIVES ANY AND ALL RECORDS, REPORTS AND OTHER INFORMATION CONCERNING THE TREATMENT OF THE PATIENT NAMED HEREIN. PHOTO STATIC COPIES OF THE AUTHORIZATION CARRY THE SAME AUTHORIZATION AS THE ORIGINAL.

DATE_____ SIGNED_____

VALID UNTIL_____ SOC.SEC.#_____

ADDRESS_____

HISTORY OF PRIOR TREATING DOCTORS:

NAME: _____

ADDRESS: _____

PHONE/FAX
NUMBER: _____

NAME: _____

ADDRESS: _____

PHONE/FAX
NUMBER: _____

NAME: _____

ADDRESS: _____

PHONE/FAX
NUMBER: _____

NAME: _____

ADDRESS: _____

PHONE/FAX
NUMBER: _____

NAME: _____

ADDRESS: _____
PHONE/FAX
NUMBER: _____

Supervisor's Workers' Compensation Incident Report Form

INJURED EMPLOYEE NAME	DATE OF THIS REPORT	ALLEGED INJURY DATE

DID YOU PERSONALLY OBSERVE THE INCIDENT INVOLVING THIS EMPLOYEE? ☐ YES ☐ NO

TO YOUR KNOWLEDGE, WAS THIS INCIDENT UNWITNESSED? ☐ YES ☐ NO ☐ I DON'T KNOW

IF YOU DID PERSONALLY OBSERVE THE INCIDENT, PROVIDE A DESCRIPTION OF WHAT YOU PERSONALLY OBSERVED, INCLUDING THE DATE, TIME AND LOCATION OF THE INCIDENT.

IF YOU DID NOT PERSONALLY OBSERVE THE INCIDENT, DID OTHERS TELL YOU ABOUT IT? ☐ YES ☐ NO

IF OTHERS TOLD YOU ABOUT IT, DESCRIBE EXACTLY WHAT THEY TOLD YOU AND WHEN THEY TOLD YOU ABOUT IT.

DID THE EMPLOYEE REPORT THIS INCIDENT TO YOU? ☐ YES ☐ NO

IF YES, STATE THE DATE AND TIME THAT THE EMPLOYEE REPORTED THIS INCIDENT TO YOU.

DID THE EMPLOYEE REPORT THE INCIDENT TO ANYONE ELSE? ☐ YES ☐ NO ☐ I DON'T KNOW

IF YES, STATE WHO THAT PERSON IS AND WHAT THE EMPLOYEE REPORTED TO THAT PERSON.

IF THIS INCIDENT WAS WITNESSED BY OTHERS, IDENTIFY THE NAMES OF ALL WITNESSES AND THEIR RELATIONSHIP TO THE EMPLOYEE (i.e., co-employee, subordinate, etc.)

WERE YOU AWARE OF ANY PHYSICAL DIFFICULTIES ON OR OFF THE JOB WHICH THE EMPLOYEE WAS HAVING BEFORE THE INCIDENT HAPPENED? ☐ YES ☐ NO ☐ I DON'T KNOW

IF YES, WHAT WERE YOU AWARE OF AND HOW DID YOU BECOME AWARE OF IT?

DESCRIBE THE EMPLOYEE'S JOB DUTIES AND WHETHER THE ACTIVITIES ON THE DATE OF INJURY WERE UNUSUAL FOR HIM OR HER TO PERFORM?

COMPLETE AND RETURN WITHIN 24 HOURS OF INJURY TO
BERNICE BILLINGS, HUMAN RESOURCES, CENTRAL OFFICE

WAS THE EMPLOYEE WEARING OR USING PROTECTIVE GEAR?	☐ YES ☐ NO ☐ I DON'T KNOW
DOES THE EMPLOYER REQUIRE THE USE OF SUCH PROTECTIVE GEAR?	☐ YES ☐ NO
DID THE EMPLOYEE ASK FOR MEDICAL ATTENTION?	☐ YES ☐ NO ☐ I DON'T KNOW
DID THE EMPLOYEE DECLINE MEDICAL ATTENTION?	☐ YES ☐ NO ☐ I DON'T KNOW
IF MEDICAL ATTENTION WAS OFFERED, WHERE WAS THE EMPLOYEE SENT?	
IF YOU ARE AWARE OF ANY HOBBIES, SECOND JOBS, SPORTS OR OTHER PHYSICAL ACTIVITIES ENGAGED IN BY THIS EMPLOYEE IN THE PAST FEW YEARS, PROVIDE THAT INFORMATION BELOW.	
IF YOU ARE AWARE OF ANY MOTOR VEHICLE ACCIDENTS, HOME INJURIES, OR SPORTS INJURIES INVOLVING THIS EMPLOYEE IN THE PAST FEW YEARS, PROVIDE THAT INFORMATION BELOW?	
ARE ANY OF THE WITNESSES TO THIS INCIDENT NO LONGER EMPLOYED BY YOUR ENTITY? ☐ YES ☐ NO	
IF ANY OF THE WITNESSES ARE NO LONGER EMPLOYED, PLEASE PROVIDE AN ADDRESS OR PHONE NUMBER OF SUCH WITNESS, IF YOU HAVE IT.	

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. KINDLY PRINT, SIGN, AND DATE BELOW.

NAME	SIGNATURE	JOB TITLE	DATE