County of Cumberland, New Jersey
OCCUPATIONAL INJURY/ILLNESS NOTICE

I _____
Employee's Name (Print) have reported a work-related injury or illness that occurred on _____. I have received the information regarding the procedure to follow if I am unable to work due to this injury or if I require medical treatment.

_____
EMPLOYEE'S SIGNATURE

_____
DATE

TO BE COMPLETED BY SUPERVISOR

1. Was emergency treatment necessary? _____yes _____no

2. Was appointment made with a panel physician? _____yes _____no

   If yes, please provide the following:

   Date of Appointment: _____

   Time of Appointment:_____

   Panel Physician's Name: _____

3. Was Qual-Lynx called to report the injury? _____yes _____no
   1-877-822-9368 (24 hrs. direct reporting service)
   Reference #_____

*4. Report **all** fatalities and **3 or more** overnight in-patient hospitalizations immediately within (8) eight hours to PEOSHA 'S 24 hr. hotline 1-800-624-1644.____yes _____(time)___not applicable. If yes, you must ask Qual-Lynx (listed above on #3) to please FAX The First State Report within 8 hours to PEOSHA 's fax hotline at (609) 292-3749 in order to avoid any fines.*

Revised 12/17
WC reports pg 1

HR Use Only
CC: Inservco _____
W/C OSHA #_____
Reportable_____
Non-reportable_____
Privacy Case_____
1st State Report_____
HR Director_____

County of Cumberland, New Jersey
OCCUPATIONAL INJURY/ILLNESS NOTICE

AUTHORIZATION TO RELEASE INFORMATION
OR TO INSPECT AND COPY MEDICAL RECORDS AND REPORTS

DATE:

TO WHOM IT MAY CONCERN:

I, hereby authorize any physician, hospital, institution or health care provider to supply any information concerning the illness or injury sustained by me including treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings provided all requests for this information are in writing. A copy of this authorization shall be considered as valid as the original.

EMPLOYEE'S SIGNATURE

SSN

DATE OF BIRTH

File number:

County of Cumberland, New Jersey
Occupational Injury/Illness
EMPLOYEE'S REPORT

(Must be filled out by the employee only.)

Name _____
(please print)

Address_____ Phone Number_____

_____
City *State* *Zip code*

e-mail address:_____

1) How many hours a day do you work?_____How many days per week?_____ Date of Hire _____
Date of Birth: _____ Marital Status_____ Number of dependents under 18-yrs of age _____
male/female _____ Average weekly wage_____ SSN_____
(These questions must be answered for direct reporting purposes.)

2) Time employee began work_____ am/pm Time of event_____ am/pm
___Check here if time cannot be determined. Where is the location the event occurred at?_____

3) Your Job Title_____ Name of Supervisor_____

ACCIDENT SUMMARY

4) Describe your activity. Please explain what you were doing, as well as the tools, equipment or materials you were using. How did the injury/illness occur?_____
_____
_____

5) What factor, object, substance or equipment contributed to your injury/illness?_____
_____
If your injury/illness was caused by another person or property, please give their name, address and telephone number here: _____
_____
_____

6) Who witnessed the start of your trouble? Please list names, addresses and telephone numbers
_____
_____

"By signing below, I understand that a false or misleading statement concerning this claim for the purpose of wrongfully obtaining workers' compensation benefits is punishable under the *Workers' Compensation Fraud Act R.S. 34:15-57.4* and benefits may be immediately terminated, all rights forfeited and I am liable to repay that sum plus simple interest."

Date _____ Signature _____

Continued on page two.

Filing of this report does not guarantee eligibility for workers' compensation benefits. It does not mean that the employer or worker was at fault or that an OSHA standard was violated.

Employee must complete both sides of this report.

County of Cumberland, New Jersey
Occupational Injury/Illness
EMPLOYEE'S REPORT

(Must be filled out by the employee only.)
This information is used to protect the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

7) Was county issued personal protective gear worn or utilized? ____*(yes/no?)* ___*or does not apply.*

If so, please state personal protection equipment provided and worn? *(Back belts, goggles, steel tipped shoes, rubber gloves, face masks, respirators, hard hats, etc.)*_____

_____

_____

8) Must answer: Describe your physical injury/illness and body part(s) affected? *Right side or left side?*_____

_____

Are you Left or Right hand dominant?_____

_____

Date of injury or onset of illness?_____

MEDICAL TREATMENT

9) Did you decline or refuse medical treatment? *(Different from first-aid)* _____ *(Yes/ no?)*

10) Name and address of attending physician or emergency room. Date/time _____

_____

Were you hospitalized overnight as an in-patient? _____ *(yes/no?)*

11) Did you remain at work?_____ How many days away from work?_____
Number of days work restricted? _____ Are you still receiving treatment? _____
(Attention: You must provide all doctors' notes to supervisor.)

12) Have you had any previous injuries/illnesses of this nature?____ *(yes/no?) If so, please give full details (dates, employers, and doctors, work-related, sports injury, MVA or other)*_____

_____

_____

_____

_____

Comments, questions or concerns?_____

_____

(If you have any questions regarding this claim please contact Human Resources, 453-2144, for the name and telephone number of this claim's representative.)

Filing of this report does not guarantee eligibility for workers' compensation benefits. It does not mean that the employer or worker was at fault or that an OSHA standard was violated.

Employee must complete both sides of this report.

County of Cumberland, New Jersey
Occupational Injury/Illness
SUPERVISOR'S REPORT

Name of injured:_____Date/Time of injury:_____

Occupation _____Dept _____ Length of service_____

Nature of injury/illness_____
Right side or Left side?*(please circle)*

(Please circle) *Vehicular Accident /Police Report Attached* *Non-Vehicular Accident*
Location of Accident:_____

Accident Review:
1) What job was employee performing? *(include tools, machines, materials or vehicle)*

_____

_____

2) What was the reason for injury/illness? *(i.e., water on floor, unsafe equipment)* Please be specific._____

_____

_____Is this a needle stick or sharps injury? _____ *(yes/no?) If yes, please enter brand of device here:*_____

3) List any witnesses to accident_____

_____

4) What improvements should be made with method, procedure or performance?

_____

_____

5) What tools, machines, equipment or supplies should be used?

_____

6) Any hazardous training required & completed for this title? _____

_____

7) What was defective or in an unsafe condition? _____

8) What steps were taken to prevent future incidents?_____

Please complete both sides of this report.

County of Cumberland, New Jersey
Occupational Injury/Illness
SUPERVISOR'S REPORT

Filing of this report does not guarantee eligibility for workers' compensation benefits. It does not mean that the employer or worker was at fault or that an OSHA standard was violated.

9) Was employee utilizing county issued personal protective equipment? ____*(yes/no?)*
Please list personal protective equipment provided and worn *(i.e., back belts, goggles, steel tipped shoes, rubber gloves, face masks, hard hats, etc.)*

_____

10) Did employee sign the *'Workers' Compensation Notice'* upon issuance of personal protective equipment?____ *(yes/no?) If yes, please attach copy.* _____*or not applicable*

Medical Treatment (must be answered)

11) Was an appointment made for medical treatment by an authorized panel physician? ___(yes/no?)
12) Did employee decline or refuse medical treatment? (different from first-aid) (yes/no?)
Was employee hospitalized overnight as an in-patient? _____
Did employee go to the emergency room? _____
13) How many full days away from work will the employee be out? _____.
Did employee provide medical certification?_____.
14) Are work restrictions imposed? _____ *(Yes/No?) If yes, what are they?*_____

_____
Will the work restrictions be accommodated for the employee? _____ *(Yes/No?)*
*If, not why?*_____

Please notify Human Resources immediately at 453-2144 whether accommodations are made or not.

Comments _____

_____

_____
This report must be forwarded to Human Resources within 4-business days. Please refer to County Policy #4.18. If you have any questions regarding this claim please contact Human Resources, 453-2144, for the name and telephone number of this claim's representative.

"I certify that I personally visually inspected the location of the accident site and any equipment, tools, machines, etc., that may have or could have contributed to this claim." *(If not, please state why?)*

Supervisor's signature: _____

(Print name) _____ Telephone # _____

Title:_____ Date of Report_____

Please complete both sides of this report.

Cumberland County Work Related Injury
LIGHT DUTY AGREEMENT

I, _____ (Name of Employee), hereby acknowledge and agree as follows:

1. Due to my current medical condition, I have certain physical limitations that prevent me from performing my normal duties at work.
2. My doctor has determined that I currently have the physical limitations described in the attached form.
3. My employer has acknowledged my current physical limitations; and has accommodated my medical needs by giving me a light duty assignment at work.
4. It is my personal responsibility to protect myself from further physical injury/harm by observing my light duty assignment at work.
5. If I am asked to perform a task at work which is outside of the physical limitations placed upon me by my doctor, I will not perform that task. Instead, I will immediately notify my supervisor and/or Department Head; and ask them to intervene if necessary.
6. I cannot and will not attempt to return to my normal duties at work unless and until I provide my employer with a letter/note from my doctor stating that I am not suffering from any medical condition that prevents me from performing my normal duties without restriction.

7. DURATION OF RESTRICTION:_____

8. DATE TO BE REEVALUATED:_____

_____ _____
Name of Employee Department Head/Supervisor

Dated:_____

Light Duty Assignment Refusal:

I hereby refuse the light duty assignment offered to me by my employer. My Department Head/Supervisor has explained my rights and benefits to me. I understand and agree that due to my refusal to accept a light duty assignment, any workers compensation benefits I am receiving may be terminated.

_____ _____
Name of Employee Department Head/Supervisor

Dated:_____