Cumberland County Injury Report

Acknowledgement

(To be completed by employee)

I (print name) _____have reported a work-related injury or illness that occurred on _____ date. 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. By signing and/or filling out this report I acknowledge..

- I have read and understand the fraud notice and all of the information provided in this report is true and accurate and no statements are false, misleading or aim to defraud the county or it's insurance carriers.
- Filing this report does not automatically entitle me to benefits from the county to cover medical care of said injury including but not limited to wage loss, health, disability or insurance benefits.
- Willful failure to use provided safety equipment and follow established safety rules can result in the loss of Worker's Compensation benefits.
- I will abide by medical advice and any/all restrictions given to me by authorized WC Doctors and personnel..

Fraud Notice

- NJ 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.
- 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 make such statements and improperly received benefits to repay the benefits to his/her employer or its insurance carrier with simple interest.
- 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.

Treatment (To be completed by supervisor)

1) Was medical treatment necessary? _____ Yes / No
2) Was appointment made with a panel physician? _____ Yes / No

Appointment date::_____ Appointment time:_____ Physician's name:_____

First Steps Upon any injury supervisors' must complete **all** steps below in order.

1. Immediately notify Christian in HR of Injury at 856-453-2144 or at ChristianLu@cumberlandcountynj.gov if after hours please send email.

2. Forward this completed report and any and all medical notes via email no later than 48 hours to Qual-lynx at **qc_wcquallynxfroi@qual-lynx.com** & **ChristianLu@cumberlandcountyNJ.gov**

3. If applicable, you must report all work-related fatalities within 8 hours; and in-patient hospitalizations, amputations, and loss-of-eye incidents within 24 hours. This information must be called in to 1-800-624-1644 and faxed to 609-292-3749. Please check off below.

❒ Not applicable, this injury does not meet the criteria in step 3

❒ Applicable, this injury was called in to **PEOSH** under step 3 on _____ date & time_____. am/pm

!! Insurance Information: Employees *may* not be required to provide their own health insurance information. Workers compensation information for the county is as follows.

Inservco Insurance Services, Harrisburg, PA 17105-1457 1-800-334-1348

Authorization to Release Information or to Inspect and Copy Medical Records and Report

To whom it may concern:

I,_____ (name) 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, 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.

Date of birth:_____ SSN:_____

Employee's Signature_____ Today's Date:_____

Demographics (please print) Employee's Report

This report must be filled out by the below named employee only.

Name:_____ Title:_____

Date of Birth:_____ Today's Date:_____ / Date of injury:_____

Please list the address at which you reside:			
Street Address		**State**	
Municipality		**Zip**	

Cell Phone #:_____ Secondary Phone #:_____ Mobile/ Home/ Work

Name of supervisor:_____ Dept/Division:_____

To whom was injury first reported to?(name/ title) _____

How many hours do you work per day?_____ How many per week?_____

What hours are you scheduled?_____ Days scheduled(circle): **S M T W T F S**

Average Weekly Wage:_____ Date of hire:_____ ❒ Alternating Schedule

Email:_____ SSN:_____-_____-_____

Are you left or right hand dominate? _____ Left / Right

Current Weight:_____ lbs Current Height: _____

If you currently work a second job please list address:_____ Schedule:_____

Please list the address where the injury occurred:		**Location # HR use only**		
Name of location		**Region/ Satellite Office** (if applicable)		
Street Address		**State**		
Municipality		**Zip**		
Location Injury occurred: Be specific (hall, room, parking lot, etc.)				

Please list the address at which you work: ❒ Check if same as above			
Name of location		**Region/ SatelliteOffice** (if applicable)	
Street Address		**State**	
Municipality		**Zip**	

Incident Summary (please print) Employee's Report (continued)

What time did you begin work?_____ am/pm Time of incident:_____ am/pm

❒ Check here if time cannot be determined

Describe what activity you were doing *before* incident occured:

_____

_____

_____

Describe how injury occurred and what factor(s) lead to injury:

_____

_____

_____

If injury happened due to another person or property please give name and contact information:

_____

_____

Please list witnesses and contact information and/or the excistence of possible video footage:_____

_____

Was county issued protective gear worn or utilized? ❒ Yes ❒ No ❒ Not applicable

If so what gear was utilized? (gloves, face masks, hard hats, belts, goggles, shoes, etc)

_____

_____

Medical Treatment (please print)

Did you decline or refuse medical treatment? (different than first-aid) _____ Yes/no

What treatment was administered to you? By who?_____

_____

Did you remain at work? _____ Yes/ no Days away from work_____ Days restricted_____

Describe your injuries:_____

_____

_____

Left or right side: Left/ Right

Name and Address of primary Doctor:_____

Name and address of pharmacy:_____

List of current medications & allergies:_____

Do you participate in any athletic, recreational or sporting activities?_____

Which?_____How Often?_____

List treating **physician**, **medications**, **dates** and **contact information** if the following apply:

Filed a claim for the same or similar condition:_____

Treated privately for the same or similar condition:_____

Treated previously by a chiropractor:_____

Treated for motor vehicle accident:_____

Treated for pain management:_____

Employee Signature:_____ Today's Date:_____

Supervisor's Report

Name of injured employee:_____ Date of incident:_____
Employee's Title:_____ Time of incident:_____
Dept /Division:_____ ❒Check here if time cannot be determined
Nature of injury/ illness:_____

Please circle: Left or Right side

Is this a needle stick or sharps Injury? Yes /No
Is this a motor vehicle accident? Yes /No
Was a police report filed? Yes/ No

If this incident is a motor vehicle accident please also fill out and submit a *county incident report*.

Location of accident:_____

Injury Review

1) What job was employee performing? Include tools, materials, vehicles, etc.)

_____
_____
_____

2) What was the reason for the injury/ illness? How did it transpire?

_____
_____
_____

3) What did you witness? _____
_____

List any other witnesses to injury:_____
_____

4) What steps were made to fix or prevent future injury?_____
_____
_____

5) Was any property or items defective?_____
_____

6) Was employee utilizing any county issued protective equipment? If so, what?_____
_____

7) Did the employee report this incident to you?_____
If so, when was incident reported?_____
If not, who reported incident to you?_____
What did they report?_____

8) Were you aware of any difficulties the employee was having before the incident occurred?_____
_____

9) Describe whether the activities on the date of injury were unusual for employee to perform:_____
_____
_____

Continue to next page.

Supervisor's Report (continued)

10) Should employee have been utilizing protective gear? Yes/ No
11) Was employee utilizing protective gear? Yes/ No
12) Did employee ask for medical attention? Yes/ No
13) Did the employee decline medical attention? Yes/ No
14) Was the employee sent to the emergency room? Yes/ No
15) Was employee admitted to in-patient overnight hospital care? Yes/ No
16) Where was employee directed for medical attention? By who?_____
_____
_____
17) Provide any hobbies, second jobs, or physical activities this employee has engaged in over the past few years:_____
_____
18) Provide any serious home, sports, or motor vehicle or work injuries involving employee in the past few years:_____
_____

Medical Treatment

19) Was appointment made for medical treatment by an authorized panel physician?_____ Yes/ No
20) Has employee been placed out of work by authorized panel physician? _____ Yes / No
If yes what is effective day employee is out of work:_____Return date:_____
21) Is employee on restricted duty?_____ Yes/ No
If yes, please lis employees restrictions:_____
How long is employee on restricted duty(please list length or expected date of dull duty return:_____
_____
22) Is the department able to accommodate employee's restricted duty? _____ Yes / No
Why or why not? _____
_____
Additional comments, or question from yourself or employee:_____
_____
_____

Inform employee that doctors notes should be handed in to supervisor and should then be forwarded with this report and for all future WC appointments until employee is declared at maximum medical improvement: MMI.

This report should be forwarded no later than 48 hours after time of incident. By signing you certify the information in this report is true, with no false or misleading statements and that you personally have inspected the location of the accident site, tools and equipment to ensure no further harm can be attributed to any persons employee or otherwise.

Signature of Supervisor:_____ Date:_____

Name (please print):_____ Title:_____

Phone number:_____ Email:_____