CHAPTER:	**8 – SAFETY AND SECURITY**	**ADOPTED: 11/21/06**
SECTION:	**2 – INJURY ON THE JOB**	**REVISED: 11/7/18**

EXHIBIT Z – REPORT OF JOB ACCIDENT

Employee's Preliminary Report of Work-Related Injury to Employer
(To be filled out by employee if possible)

IT IS THE RESPONSIBILITY OF THE EMPLOYEE TO SIGN ALL NOTES FOR EACH AND EVERY VISIT TO A MEDICAL PROVIDER AND TO NOTIFY HIS/HER DEPARTMENT OF WORK STATUS IMMEDIATELY AFTER EACH DOCTOR'S VISIT.

Safety should be notified immediately of all accidents and/or injuries. On the day of the occurrence, this form should be completed and faxed to Safety at (856) 384-6997 as soon as possible.

Date of Report: _____ Reported injury to whom: _____

Employee's name _____

Date of injury_____ Date reported_____

Time employee started work_____ Time of accident_____

Place where injury happened _____

Detailed description of how injury occurred and if any piece of equipment was being used:

_____

_____

What part(s) of the body were injured and what part(s) of the body do you currently feel pain?

_____

Is the employee requesting medical treatment at this time? ___ yes ___ no

Job Title_____Department_____

Full Time or Part Time Employee _____

Employee's address _____

City _____ State _____ Zip _____

Phone number_____

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 _____ Date: _____

Supervisor Name (please print)_____

Supervisor Signature _____ Date: _____

IF MEDICAL TREATMENT IS NOT REQUIRED,
REMAINDER OF THE FORM DOES NOT
NEED TO BE COMPETED.

Social Security Number_____

Date of Birth_____ Date of Hire_____

Witness_____ Phone Number _____

List your primary care physician and his/her address and phone number for the past 10 years:

_____

Have you had treatment in the past for the same or similar medical conditions? ____yes ____no

If yes, 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 by a chiropractor in the past 5 years? ____ yes _____no

If yes, name and address of chiropractor

_____

Have you ever filed 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 collision in the past 5 years? ___ yes ____no

If yes, provide the details of the crash, date and the nature of the injury and treatment.

_____

Have you had any MRI's, CT scans and/or X-ray in the past 5 years? ____yes____no

If yes, please provide the details and the nature of the injury ._____
_____

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. _____
_____

Have you ever received pain management treatment? ____Yes ____No

Requesting Leave related to an On-the-Job Injury or Illness

Should your injury be substantiated, it is important for you to be aware that only a GCIC authorized treating physician can authorize time off from work for an on-the-job injury or illness. The following procedures should be followed when seeking leave for a work-related injury:

1. If you are unable to report to work or complete a shift due to an issue arising as a result of your work-related injury, you should contact the treating physician immediately. Your GCIC authorized treating physician is:

   _____ Phone: _____

   - The only exception to this policy is if the issue constitutes a medical emergency in which case you should seek immediate treatment at a hospital emergency room.

   - You should contact the treating physician even if the issue arises during the treating physician's non-business hours. During non-business hours, such calls will be answered by the treating physician's answering service or voice mail (which will instruct you on how to reach the treating physician or the on-call physician).

2. You must also notify Safety Staff immediately by calling (856) 384-6994 or (856) 384-6993. If the call is placed after normal business hours, you should leave a detailed voice-mail message.

3. You are also obligated to communicate with your supervisor to keep that person apprised of the situation. Your Department Supervisor is:

   _____ Phone: _____

You are reminded that the GCIC authorized treating physician is the only person that can authorize time off from work for an On-the-Job injury or illness.

By signing below you acknowledge that you have read these procedures.

_____

Employee Date

THIS FORM MUST BE SIGNED AND RETURNED

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:4303b(2), crimes of the fourth degree are punishable by imprisonment for up to 18 months and fines of $10,000.

P.L. 1998, Chapter 74, also creates civil liability for all damages, costs and attorneys fees payable to the injured party attributable to wrongfully obtained benefits. This would require employee who make 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.

_____
Employee Signature

_____
Date

AUTHORIZATION FOR RELEASE OF INFORMATION IN CONNECTION WITH WORKERS' COMPENSATION

TO: RE:

I. Pursuant to my privacy rights under the Health Insurance Portability and Accountability Act (HIPAA), by affixing my signature below I understand and voluntarily consent to the following:

I hereby request and authorize that you disclose, make available and furnish to:

INSERVCO INSURANCE SERVICES, INC.
New Jersey Claim Service Office
PO Box 1457
Harrisburg, PA 17105-1457

1.) Office notes; 2.) Charts; 3.) Diagrams; 4.) Pathology reports; 5.) Operative reports; 6.) Physical and lab tests; 7.) X-ray/imaging reports; 8.) X-ray/imaging films; 9.) Prescription notes; 10.) Treatment plans; and 11.) Discharge summary, with regard to the above named individual, from the inception of your records to the present.

This authorization specifically excludes the release of health information related to psychiatric or mental health treatment, treatment of drug and/or alcohol abuse; treatment of Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV); and sexually transmitted diseases/viruses.

II. Rights and obligations under HIPAA:

A. Purpose of this request: I understand that the information listed above in Section I is being requested by Inservco Insurance Services, Inc. for the specific purpose of investigating the pending workers' compensation claim I filed against the above named respondent/employer/third party payor and by signing this authorization I voluntarily consent to its release.

B. Expiration Date: Unless otherwise revoked, this authorization will expire six (6) months after the date of this authorization;

C. Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that the revocation must be in writing to the above named doctor/facility authorized to make this disclosure. I further understand that the revocation is only effective after it is received by the above named doctor/facility and does not apply to information that has already been release in response to this authorization.

D. Impact on Medical Treatment: I understand that my right to treatment, payment, enrollment or eligibility for benefits is not conditioned on me signing this authorization.

E. Subsequent Disclosure: I understand that any disclosure of information may be subject to re-disclosure by INSERVCO INSURANCE SERVICES, INC. and may no longer be protected by federal or state law.

_____ _____

Signature of Patient Date

_____ _____

Signature Authorized Representative/Guardian in lieu of Patient Date

By signing this authorization, the Authorized Representative and/or Guardian certifies that he or she has the authority to act on behalf of the person identified above on the basis of (please explain):

_____

_____

_____

_____

Claim Number

Please list the name and address of your primary care physician, any other doctor or medical facility that you may have used in the last 5 years. This information can also be faxed back to us when it is completed.

Thanks for your anticipated cooperation.

Inservco Insurance Services

Name of your Primary Doctor: _____

Address: _____

_____

Phone # _____

Below please list any other doctor/doctors that you have treated with in the past 5 years:

Doctor's name: _____

Address:

_____

_____

Phone# _____

Claimant's Signature: _____

Date: _____