WORKER'S COMPENSATION

Pemberton Township Board of Education

First Report Employee Injury/Treatment Form

Per District Policy 8440, all work-related injuries must be reported to the Nurse or Susan McGuinness (609) 893-8141 Ext 1004 within 24 hours of the injury.

Call 1-800-425-3222 to report an after normal hours injury

TO BE COMPLETED BY THE INJURED EMPLOYEE:

Name: _____ Date of Birth: _____

Address: _____ Contact Number: _____

_____ Alt. Number: _____

Job Title: _____ Do you work for the district in another capacity? (e.g. 21st Century, Champions, Athletic Coach)

Date of Injury: _____ Time: _____ AM/PM _____

Supervisor: _____ Building: _____

Work Hours: _____ Where Accident Occurred:_____

Explain what you were doing when the injury occurred/What caused the injury: _____

_____

_____

_____

Describe your injuries as it relates to this incident: _____

_____

_____

Have you had this injury in the past: Explain: _____

_____

_____

Was the injury caused by another person? Circle One: YES NO

If Yes, please circle one: Staff Student Visitor

Student Grade: _____ Was this intentional? Circle One: Accidental Intentional

List the Name of any Witnesses: _____

Signature of Injured Worker: _____ Date: _____

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TO COMPLETED BY TREATING NURSE:

Injuries Reported: _____

Treatment Provided: _____

Witness Form Received: Yes: _____ No: _____ N/A: _____

Date received from Injured Worker: _____

Disposition: RTW: _____ W/C Dr: _____ ER: _____

Nurse's Signature _____ Date: _____

TO BE COMPLETED BY INJURED EMPLOYEE

By signing below, I affirm that I have been offered and refused the following at this time:

_____ Medical Treatment by School Nurse

_____ Medical Treatment by an Approved Physician

I recognize that if I would like to received medical treatment for this injury at a later date, I must contact Susan McGuinness in order to obtain the necessary authorization for an appointment.

Employee's Signature: _____ Date: _____

APPROVED PHYSICIANS:

Carbon Health (Formerly CJUC) Phone: 609-757-1717 Hrs: Mon – Fri 8:00 am to 8:00 pm
6 Earlin Ave, Ste 140, Browns Mills, NJ 08068

Med Express Phone: 609-8712045 Hrs: Mon – Fri 8:00 am to 8:00 pm
4318 Route 130 N., Willingboro, NJ 08046

Concentra Phone: 609-747-1891 Hrs: Mon – Fri 7:30 am to 5:00 pm
2103 Burlington Mt Holly Rd, Burlington, NJ 08106

TO BE COMPLETED BY WORKER'S COMPENSATION COORDINATOR

EE SSN: _____

DOH: _____

Salary: _____

WORKER'S COMPENSATION

INJURY WITNESS REPORT

Your Name: _____ **Contact number:** _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Injured Employee: _____

Date of Witnessed Injury: _____ Time of Injury: _____

Exact Location (School & Area): _____

Did you Witness the injury to the Above-Named Party? Yes_____ No_____

Explain in detail what the above party was doing when the injury occurred/What caused the injury: _____

_____

_____

_____

_____

What injuries appear to have been sustained by the injured party: _____

_____

_____

_____

_____

I certify that this witness report has been read and completed to the best of my ability and that all information submitted is true.

Signed: _____ Date: _____

WARNING

34:15-57.4. Workers' Compensation fraud; criminal and civil penalties, a crime of the fourth degree if the person purposely or knowingly:

(1) Makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining the benefits;

(2) Makes a false or misleading statement, representation or submission, including a misclassification of employees, or engages in a deceptive leasing practice, for the purpose of evading the full payment of benefits or premiums pursuant to R.S. 34:15-1 et seq; or

(3) Coerces, solicits or encourages, or employs or contracts with a person to coerce, solicit or encourage, any individual to make a false or misleading statement, representation or submission concerning any fact that is material to a claim for benefits or the payment of benefits or premiums, pursuant to R.S. 34:15-1 et seq. for the purpose of wrongfully obtaining the benefits or of evading the full payment of the benefits or premiums.

INJURY REPORTING PROCEDURES
EFFECTIVE January 1, 2016

General Procedure: If you are injured while on the job, you must report the incident to your supervisor or the school nurse and call Sue McGuinness at 609-893-8141 ext 1004 even if you do not wish to see a doctor. No medical payments will be made without obtaining a Provider Referral to take with you when you go for medical treatment.

Normal Operating Hours: See your supervisor or school nurse. Fill out a First Report of Injury Form. Wait for your supervisor or school nurse to report the claim and make the doctor appointment.

After Normal Operating Hours (evenings and weekends): If you do not want to see a doctor, fill out a First Report of Injury form with your supervisor or school nurse as soon as possible. If you need medical assistance, notify your supervisor or a district representative, and then call 1-800-425-3222 to report the injury and receive instructions for medical treatment.

Emergency Situations (Emergencies that are life and/or limb threatening): If you require emergency care, go to the nearest emergency room and have them call 1-800-425-3222 to report your injury. Have someone report the injury to your supervisor or a district representative as soon as possible.

Designated District Supervisors:

Scott Krisanda	Buildings and Grounds/Custodial Injuries	609-217-8723
Barbara Wells	Food Service Injuries	609-217-8740
Jim Carmichael	Transportation Injuries	609-893-8141 x 1186