EAST RUTHERFORD
WILDCATS

EAST RUTHERFORD PUBLIC SCHOOLS

Office of the Board of Education

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East Rutherford, NJ 07073
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www.erboe.net

TO: All Staff

FROM: Giovanni A. Giancaspro, Superintendent

RE: Workers' Compensation

Please be advised that should a **work-related injury** occur as a result of performing your job responsibilities the required procedure for reporting and/or seeking treatment for the injury is as follows:

1. All accidents must be reported **immediately** to an employee's supervisor **and** the school nurse. Should the nurse be unavailable, please report to the main office.

2. The school nurse (*or staff member)* will contact First MCO via the 800 number (800) 831-9531 to report the injury. First MCO's toll-free number, for the reporting of injuries, is available 24 hours, seven days per week.

3. A First MCO specialist will gather all information required by the State during your call, such as: Name, address, telephone number, date of birth, Social Security Number, how the incident occurred, what the injuries are, date hired, hours worked and salary.

4. First MCO **will direct** the injured employee to a medical facility.

5. Should the injury be life-threatening you should report to your nearest hospital emergency room. **Following treatment** in the Emergency Room you will need to call the school nurse (*or designated staff member*) so the report of injury can be made with First MCO and further care will be directed.

   In all cases, First MCO will manage your care, referring you and making your appointments when necessary with specialists as well as following up with you to monitor the improvement of your medical condition.

6. The following two forms must be completed and sent to the (*school nurse):*

   1. **Workers' Compensation Questionnaire** – injured person should complete this form and sign

   2. **Supervisor's Accident Investigation Report** – completed by immediate supervisor

7. Strict adherence to the above procedures will facilitate processing of all Workers' Compensation Claims or possible claims.

8. Final determination of benefits shall be determined by the administrator of the Plan and not the Board of Education.

INSERVCO
INSURANCE SERVICES, INC.

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 WITNESSED? ☐ 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?

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

Return to Inservco Insurance Services
P.O. Box 1457, Harrisburg, PA 17105

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 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.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital or other person or institution to permit the Inservco Insurance Services or its representative to examine, make, or be furnished with any information concerning illness or injury sustained by me including treatment, consultations, medical history, hospital records, prescriptions, diagnosis, or findings. A Photostatic or scanned copy of this authorization shall be considered as valid as the original.

EMPLOYEE SIGNATURE	SOCIAL SECURITY #.	DATE

I: employee acc. rpt