WORK RELATED INJURIES

**1. Medical Treatment**

**2. Document Accident**

**3. Call Gallagher**

**4. Send Report to HR**

**Instructions:** Please follow these steps to ensure work related injuries and/or illnesses are documented properly and reported in a timely manner to a supervisor, our workman comp carrier and the HR Department.

**For severe injuries, call 911 immediately!** For non-emergencies an employee can be seen at an agency’s approved Medical Service Provider. (See attached).

Notify either the health care service provider this is a work related injury.

**Employee Non-Vehicle Accident Report** form - Needs to be completed as soon as possible or a Vehicle Accident Report form for car accidents. (Please be as detailed as possible when completing the report)

- If the employee is unable to complete the report a supervisor (preferred) or co-worker may complete the report on their behalf – both individuals are to sign form (the injured employee can sign at a later date if necessary).

**Call Workman Comp Carrier** – During the business hours (M-F 8:30AM-4:30pm) Human Resources will contact our workman comp carrier, Gallagher Bassett, to report the injury. The accident report must be sent to the HR Department or email desiree@ccpaterson.org or via HR fax 973-333-6031.

- **Outside of HR Business Hours:** Accidents must be reported in a timely matter, a supervisor must contact Gallagher Bassett to report the injury. Please be sure to get the Loss Number from the representative before completing your claim over the phone – write the loss number on the accident report.

**Gallagher Bassett (Report an Injury): 877-509-3503**

Have the completed accident report in hand when calling.

**Send Report to HR-Desiree Garcia, Jr. HR Generalist desiree@ccpaterson.org or via fax 973-333-6031. Questions or Concerns call Desiree at 973-847-9037 or Hope Eder, Director of Human Resources at 973-557-9217 or hope@ccpaterson.org.**
# Employee Non-Vehicle Accident Report Form

## Employee Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Home Address</td>
<td></td>
</tr>
<tr>
<td>Phone #</td>
<td></td>
</tr>
<tr>
<td>Sex (Circle One): Male</td>
<td>Female</td>
</tr>
<tr>
<td>Agency (circle one): Straight and Narrow</td>
<td>DPD</td>
</tr>
<tr>
<td>Department</td>
<td></td>
</tr>
<tr>
<td>Position</td>
<td></td>
</tr>
<tr>
<td>Supervisor</td>
<td></td>
</tr>
<tr>
<td>Status (Circle one):</td>
<td></td>
</tr>
<tr>
<td>Does employee have outside employment? (Circle one)</td>
<td>YES</td>
</tr>
<tr>
<td>If yes, please indicate the name of the company and the title:</td>
<td></td>
</tr>
</tbody>
</table>

## Injury Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Injury</td>
<td></td>
</tr>
<tr>
<td>Time of Injury</td>
<td>AM/PM</td>
</tr>
<tr>
<td>Hours of employment: From:</td>
<td>To:</td>
</tr>
<tr>
<td>What location did the injury occur (building)?</td>
<td></td>
</tr>
<tr>
<td>To whom was the injury reported (Name and Contact info):</td>
<td></td>
</tr>
<tr>
<td>Was First-Aid provided to the employee?</td>
<td>YES</td>
</tr>
<tr>
<td>If yes, by whom?</td>
<td></td>
</tr>
<tr>
<td>Please describe First-Aid given to employee:</td>
<td></td>
</tr>
<tr>
<td>Did employee work remainder of shift?</td>
<td>YES</td>
</tr>
<tr>
<td>Was the employee sent to the hospital?</td>
<td>YES</td>
</tr>
<tr>
<td>Was the employee sent Home or to Agency's Medical Service Provider (i.e. Concentra or Valley)?</td>
<td></td>
</tr>
<tr>
<td>Did employee refuse medical treatment?</td>
<td>YES</td>
</tr>
<tr>
<td>If yes, please indicate why</td>
<td></td>
</tr>
<tr>
<td>Witnesses(s) (Name and Contact info):</td>
<td></td>
</tr>
</tbody>
</table>

**Please describe the accident/injury below (be specific):**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Employee Accident/Incident Report Form (Cont’d)

Type of Injury Sustained
Please circle all that apply:
Right Side  Left Side
  Abrasion
  Blow/Strike
  Burn
  Chemical
  Cut
  Puncture
  Slip/Fall
  Spain/Strain
  Other (Explain Below):

Additional Comments:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

For HR Use ONLY
OSHA Reportable (circle one): YES  NO
Loss #:
Reported by:
Date of report:
Uploaded to Paylocity:

Employee Signature: ____________________________________ Date: ________________________

Preparer Signature (if applicable): __________________________ Date: ________________________
If you have experienced a work related injury, please go to:

Concentra

238 Piaget Ave
Clifton, NJ 07013
Phone: 973-772-3930
Hours: Mon-Fri 8:00am to 7:00pm

OR

Valley Medical Group

72 Hamburg Tpk.
Riverdale, NJ 07457
Phone: 973-835-7290
Mon-Fri 8:00am to 8:00pm, Sat. 8am-4pm, Sun 8am-2pm

All employees who experience a work related injury must go to the clinic immediately!

Forms needed for:

- Authorization Form
Authorization for Examination or Treatment

Patient Name: __________________________ Social Security Number: __________________________

Employer: __________________________ Date of Birth: __________________________

Street Address: __________________________ Location Number: __________________________

Temporary Staffing Agency: __________________________

Work Related

☐ Injury  ☐ Illness

Date of Injury __________________________

Substance Abuse Testing* (check all that apply)

☐ Preplacement  ☐ Baseline  ☐ Annual  ☐ Exit

Physical Examination

☐ Preplacement  ☐ Recertification

DOT Physical Examination

Special Examination

☐ Preplacement  ☐ Reasonable cause

☐ Hair collect

☐ Asbestos  ☐ Respirator  ☐ Audiogram

☐ Non-regulated drug screen  ☐ Rapid drug screen

☐ Other __________________________

☐ Rapid drug screen

☐ HAZMAT  ☐ Medical Surveillance

☐ Other __________________________

Type of Substance Abuse Testing

☐ Preplacement  ☐ Reasonable cause

☐ Post-accident  ☐ Random

☐ Collection only  ☐ Hair collect

☐ Non-regulated drug screen  ☐ Rapid drug screen

☐ Other __________________________

☐ Non-regulated drug screen

☐ Other __________________________

Billing (check if applicable)

☑ Employee to pay charges

Special instructions/comments: __________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Authorized by: __________________________ Please print

Phone: __________________________ Date

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Concentra now offers urgent care services for non-work related illness and injury. We accept many insurance plans.

(Copies of this form are available at www.concentra.com)

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