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.
# Catholic Charities
## Employee Non-Vehicle Accident Report Form

### Employee Information

<table>
<thead>
<tr>
<th>Employee Information</th>
<th>Today's Date: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name:</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Home Address:</td>
<td>Phone #:</td>
</tr>
<tr>
<td>Sex (Circle One):</td>
<td></td>
</tr>
<tr>
<td>Agency (circle one):</td>
<td>Department:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Position:</td>
<td>Supervisor:</td>
</tr>
<tr>
<td>Status (Circle one):</td>
<td></td>
</tr>
<tr>
<td>Does employee have outside employment? (Circle one):</td>
<td>YES NO</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>Injury Information</th>
<th>Date of Injury: ____________________ Time of Injury: ______________ AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours of employment:</td>
<td>From: __________ To: __________ What location did the injury occur (building)?</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 NO</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 NO</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 NO</td>
</tr>
<tr>
<td>Witnesses(s) (Name and Contact info):</td>
<td></td>
</tr>
<tr>
<td>Please describe the accident/injury below (be specific):</td>
<td></td>
</tr>
</tbody>
</table>
Employee Accident/Incident Report Form (Cont’d)

Additional Comments:
__________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________

Employee Signature: __________________________ Date: __________________________

Preparer Signature (if applicable): __________________________ Date: __________________________

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):

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

Catholic Charities – Human Resources Department   775 Valley Road, Room 209 Clifton, New Jersey 07013
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

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

Forms needed for Concentra:
- 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)

- [ ] Regulated drug screen
- [ ] Breath alcohol
- [ ] Collection only
- [ ] Hair collect
- [ ] Non-regulated drug screen
- [ ] Rapid drug screen
- [ ] Other ___________________________

**Physical Examination**

- [ ] Preplacement
- [ ] Baseline
- [ ] Annual
- [ ] Exit

**DOT Physical Examination**

- [ ] Preplacement
- [ ] Recertification

**Special Examination**

- [ ] Asbestos
- [ ] Respirator
- [ ] Audiogram
- [ ] Human Performance Evaluation
- [ ] HAZMAT
- [ ] Medical Surveillance
- [ ] Other ___________________________

**Type of Substance Abuse Testing**

- [ ] Preplacement
- [ ] Reasonable cause
- [ ] Post-accident
- [ ] Random
- [ ] Follow-up

**Billing** (check if applicable)

- [ ] Employee to pay charges

**Special instructions/comments:** ___________________________

- ___________________________
- ___________________________
- ___________________________

Authorized by: ___________________________ Title: ___________________________

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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