RIDGEWOOD PUBLIC SCHOOLS

Julie Kot
Business Administrator/
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Ridgewood Public Schools
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TO: School Nurses/All Staff

FROM: Julie Kot

DATE: September 1, 2023

RE: Workers' Compensation Procedures

Greetings!

If, during the course of performing their job responsibilities, an employee experiences a work-related injury, the following procedure for reporting and/or seeking treatment must be followed:

1. All accidents must be reported immediately to the employee's supervisor and the school nurse.
2. The school nurse will contact First MCO at (800) 831-9531 to report the injury. First MCO's toll-free reporting line is available 24 hours a day, seven days a week.
3. A First MCO Specialist will gather information required by the State during the call, such as name, address, telephone number, date of birth, Social Security number, how the incident occurred, what the injuries are, date of hire, hours worked, and salary, etc.
4. The First MCO Specialist will direct the injured employee to an approved medical facility.
5. If the injury sustained rises to the level of an emergency, the employee should report to the nearest Hospital Emergency Department. Following treatment in the Emergency Department, the employee will need to contact the school nurse so the report of injury can be made to First MCO, and further care will be directed by a Specialist.
6. If an injury occurs after work hours and rises to the level of an emergency, the injured employee should go to the nearest Emergency Department for care. The next day, the school nurse should be notified and will follow the above procedures. The injured employee should only

go to the Emergency Department independently if there is a true emergency. The claim needs to be reported to First MCO as soon as possible so a Specialist can begin medically managing and directing care.

7. The following two forms must be completed and sent to the school nurse:
    a. Employee Accident Form – completed and signed by the injured employee.
    b. Supervisor's Workers' Compensation Incident Report Form – completed and signed by the employee's immediate supervisor.
8. Strict adherence to the above procedures will facilitate proper processing of all Workers' Compensation claims or potential claims.
9. The final determination of benefits shall be made by the Plan Administrator, not the Board of Education.

If there are any questions, please do not hesitate to contact Maryjane Moynihan for clarification at ext.10535.

Thank you for your attention to this matter. Wishing you all a wonderful and safe 2023-2024 school year!

Regards,

Julie Kot

Business Administrator
Ridgewood Public Schools

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

INSERVCO
INSURANCE SERVICES, INC.

Supervisor's Workers' Compensation Incident Report Form

EMAIL: insvnj@pnat.com

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

Witness Form

FULL NAME OF WITNESS	JOB TITLE OF WITNESS

IN YOUR OWN WORDS, WRITE WHAT YOU PERSONALLY WITNESSED (NOT WHAT WAS TOLD TO YOU BY OTHERS)

WHAT DATE AND TIME DID YOU WITNESS THE ABOVE ACCIDENT?

WHEN YOU WITNESSED THE ACCIDENT, WHERE WAS THE INJURED EMPLOYEE?

AT ANY TIME DID THE INJURED EMPLOYEE ASK FOR MEDICAL TREATMENT OR COMPLAIN ABOUT ANY SPECIFIC LOCATION OF PAIN? IF SO, PLEASE SPECIFY

WHAT, IF ANYTHING DID THE INJURED EMPLOYEE SAY OR DO?

HAVE YOU SPOKEN WITH THE INJURED EMPLOYEE SINCE THE ACCIDENT DATE? IF SO, WHAT WAS THE NATURE OF THE CONVERSATION?

PLEASE IDENTIFY ANY OTHERS WHO WERE PRESENT WHEN YOU WITNESSED THE ACCIDENT.

DID YOU REPORT ANYTHING TO HUMAN RESOURCES OR SUPERVISORY STAFF ABOUT WHAT YOU WITNESSED?

DID YOU NOTICE ANY SUBSTANCE OR OBJECT THAT APPEARED TO CONTRIBUTE TO THE INJURY? IF SO, PLEASE IDENTIFY THAT SUBSTANCE OR OBJECT.

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.

SIGNATURE OF WITNESS	SUPERVISOR'S SIGNATURE AND I.D.	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 provider 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:43-3b(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 attorney's fees payable to the injured party attributable to wrongfully obtained benefits. This would require employees 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