Hanover Township Fire District No. 3

PERSONNEL INJURY/EXPOSURE REPORT & FORMS

If you are injured and need medical attention please seek that attention immediately. All Fire District Personnel, Career or Volunteer seeking medical assistance/care for an injury or illness or exposure related to your employment with the District should go to Morristown Medical Center or FastER Urgent Care. You are to immediately notify your Officer / Crew Chief of any injury, illness, exposure or suspected exposure related to your activities/employment with the District.

If at all possible, please bring this document with you.

Enclosed you will find:

- **Claims Kit** identifying injury processes
- **Employee Injury Report** – You must complete this immediately, or as soon as is possible
- **Supervisor's Report of Injury** – Your supervisor must complete this
- **First Report of Injury/Illness** – Your supervisor must complete this
- **Pathogens/Exposure Incident Report** – Your supervisor must complete this
- **HIPAA Disclosure** – You must complete this
- **Medical Treatment Provider List** – You must complete this
- **VFIS Accident/Sickness Claim Report** – Complete all highlighted areas
- **Attending Physician's Statement** – Try to have whomever is treating you complete this. You sign where highlighted, physician or medical provider also signs their highlighted location
- **Investigation Report** – This is to be completed by your supervisor or personnel assigned by District

You are required to complete all of the forms to the best of your abilities and knowledge. When needed, your employer of record is **Hanover Township Fire District No. 3, PO Box 511, cedar Knolls, NJ 07927-0511**

7710 SERVCO

Claims Kit

What to do when an injury occurs:

1. MEDICAL TREATMENT immediately refer injured worker to closest directed care medical clinic or emergency room!

CAUTION!!!

In the event that an injured employee appears or seems to be unable to drive himself to a clinic, for any reason, the supervisor or another employee should assist that injured worker and inform another employee to call 911.

2. REPORT YOUR WORK-RELATED INJURY TO SUPERVISOR
3. Supervisor completes "EMPLOYERS REPORT OF INDUSTRIAL INJURY" - Individual State Form
4. Employee completes "WORKERS COMPENSATION INJURY NOTICE" - Form B
5. Supervisor completes "SUPERVISOR'S REPORT OF INJURY" - Form C
6. Witness completes "WITNESS STATEMENT" – Form D
7. Employee completes "AUTHORIZATION TO DISCLOSE, RELEASE AND USE PROTECTED HEATH INFORMATION – HIPAA" – Form E
8. Employee completes "MEDICAL TREATMENT PROVIDER LIST" – Form F
9. Supervisor to scan and email the above completed forms to: claims@7710insurance.com

EMPLOYEE INJURY REPORT

*** THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE**

(Please complete on the day of injury and return to supervisor)

Employee Name (Last, First, Initial):

Length of Time in Current Position: Dated Reported:

Accident Reported to: Date of Injury:

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐

Number of Children Under 18:

Description of Incident-Explain Fully How Incident Occurred:

Witnesses to Incident:

Explain where accident happened (Floor, room, location-be specific):

I UNDERSTAND A WORKERS' COMPENSATION CLAIM WILL BE SUBMITTED ON MY BEHALF. SUBMISSION OF THIS CLAIM MAY RESULT IN MY RECEIPT OF WORKERS' COMPENSATION BENEFITS PURSUANT TO THE ILLINOIS WORKERS' COMPENSATION ACT. ANY PERSON WHO MAKES OR CAUSES TO BE MADE ANY KNOWINGLY MATERIAL MISREPRESENTATION FOR THE PURPOSES OF OBTAINING WORKERS' COMPENSATION BENEFITS OR PAYMENT MAY BE GUILTY OF A CRIME.

Employee Signature Date

7710 SERVCO

SUPERVISOR'S REPORT OF INJURY

Policy Holder Name: _____

Date of Injury:_____ Time of Injury:_____

Injured Worker's Name:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Telephone Number:_____ Social Security Number:_____

Employee Date of Birth:_____ Email:_____

☐Male ☐Female ☐ Married ☐Single _____ # Dependents _____ Avg Weekly Wage

Date of Hire_____ Last Day Employee Worked _____

Who reported the accident:_____

When was injury/illness reported:_____

Type of injury:_____

What was the employee doing when injury occurred:_____

_____

Any Witnesses:_ ☐Yes ☐ No IF YES, Who_____

Please describe the accident. (Include events leading up to the injury and any objects or substance involved.)

_____

_____

_____

_____

Did employee seek medical attention: ☐ Yes ☐ No

Could this injury have been prevented: ☐ YES ☐ No Please Explain:_____

_____

_____

What did anyone do, or fail to do that caused the accident/injury:_____

_____

Was this injury the result of unsafe working condition(s): ☐ YES ☐ No Please Explain:_____

_____

_____

What action(s) have been taken to prevent injuries from occurring again:_____

_____

Have you any reason to believe this was NOT an on-the-job injury ☐ YES ☐ No

If Yes, Please Explain in detail:_____

_____

_____

Is the employee alleging a Workers' Compensation Claim? ☐ YES ☐ No

Has the employee missed any time from work resulting from this injury? ☐ YES ☐ No

If Yes, Please list the dates of complete shifts the employee missed, but would have normally worked:_____

_____

Has the employee returned to work? ☐ YES ☐ No If Yes, Date of Return:_____

I understand that falsification of this statement, or any misrepresented information contained in this statement, can result in disciplinary action.

_____ _____

Supervisor Signature Date

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
Hanover Township Fire District 3 PO Box 511 Cedar Knolls, NJ 07927-0511	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) 82 Ridgedale Avenue Cedar Knolls, NJ 07927		LOCATION # PHONE # 973-267-5659
INDUSTRY CODE	EMPLOYER FEIN 22-2378190		

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD TO CHECK IF APPROPRIATE ☐ SELF INSURANCE	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX M MALE F FEMALE U UNKNOWN	MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO WERE THEY USED? ☐ YES ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

7710 INSURANCE

Pathogens - Exposure Incident Report

Employee Instructions
You are completing this form because you have experienced an actual or a potential exposure to blood or other potentially infectious material. An evaluation of this exposure is required by regulation.

Please complete all the information below. Take this form with you when you go to a physician or other healthcare provider for the evaluation of the exposure. The information contained on this form is crucial to a proper evaluation of the exposure. Please take the time and care in completing the form to insure that the information is clear and accurate. If you need information on where to have this medical evaluation performed, please contact your supervisor.

Employee's Statement: (Please Print)

Name: _____

Job Title: _____ Work Location: _____

Work Phone: _____ Supervisor: _____

Description of Exposure Incident

Incident or response number: _____

Date: _____ Time: _____ am / pm

City/Town: _____ State: _____

Describe Incident (Please include the type of infectious material to which you were exposed and the circumstances of the exposure – response to the call – protocols followed or breached due to circumstances uncontrollable):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Supervisor's Statement: (Please Print)

Employee's Name: _____

Supervisor Identification.

Name: _____

Work Phone: _____

Description of Incident
(Please describe the employee's duties as they relate to the exposure incident):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Hepatitis B Status

The employee named above has / has not (circle one) received a three dose series of hepatitis B Vaccine. If yes, the series was completed on _____ (date).

Investigation of Source

Please describe what information is known about the source of the exposure (the incident number, person's name, address, telephone number, or other contact point), the result(s) of the blood testing of the source person (if known), or why blood testing of the source person is not feasible. Also, if the source person is known to have or test positive for hepatitis B or human immunodeficiency virus (HIV), please indicate this fact. The source person must be tested for these agents unless such testing is not legally possible.

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION TO DISCLOSE, RELEASE AND USE
PROTECTED HEALTH INFORMATION
(HIPAA COMPLIANT)

To:

This authorization permits you to release a copy of ***any and all*** records in your possession regarding any medical treatment and/or hospitalization of:

Name of Claimant:_____ **Date of Birth:**_____

Social Security Number:_____

Date(s) of Injury/Occupational Disease:_____

By execution of this Authorization I consent that my employer, anyone acting on their behalf including, but not limited to, their insurance carrier, attorney or other representative, shall be permitted to examine and obtain copies of all hospital, medical, educational and vocational records of every sort and kind, review records of any insurance company, interview all doctors, rehabilitation professionals, venders, and all former and subsequent employers regarding all matters relating to any issue relevant my Workers' Compensation Claim.

I AUTHORIZE you to disclose any information and records regarding the above named individual in your possession. This includes but is not limited to, your medical findings, diagnosis, treatment, treatment summaries, psychological or psychiatric evaluations, prognosis, clinic notes, diagnostic reports or radiology films, physical therapy records, pharmacy records, or any other heath information in your records. I understand that based on the information released it may include information related to any substance abuse.

I UNDERSTAND that the information furnished may be used to evaluate and verify my claim for benefits for a work related injury or occupational disease. The information obtained is relevant to a workers' compensation claim(s) and may be used by persons or organizations performing a service related to, or adjudicating the claim(s).

THIS AUTHORIZATION will expire 90 days following a resolution of the workers' compensation claim(s) but may be revoked by signator in writing to the requesting party. Revocation of this authorization will not be valid if the requesting party has taken action in reliance upon such authorization. Please note that the information disclosed or used pursuant to this authorization may be subject to re-disclosure and would, therefore, no longer be protected under the terms of the HIPAA privacy rule.

A PHOTOSTATIC COPY of this authorization shall be deemed to have the same authority as the original.

I hereby certify that I have read the provisions in this authorization. I understand and agree to its terms, and authorize disclosure of the information described above.

_____ _____

Claimant Date

Form E

MEDICAL TREATMENT PROVIDER LIST

(for injured employee to complete)

Claimant Name:_____ Social Security Number:_____
Address:_____ Date of Injury:_____
_____ Employer:_____
Telephone Number:_____ Cell Number:_____

"Notification to the Workers' Compensation Claimant"
We are asking that you please fill out this form to help expedite the Workers' Compensation claim filed.
Please list all the medical providers for industrial injury first.

Please list any other medical providers who have treated you for any medical problems within the past years (up to 15 years)

_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____

Please attached additional pages, if necessary

Requesting Party:
Address:
Phone Number:
Fax:
Relationship to the Claimant: Adjuster

Failure to return this form to the requester may result in a delay or denial of your claim Form F

ACCIDENT/SICKNESS CLAIM REPORT

Please Complete and Mail to:

Glatfelter Claims Management, Inc.
P.O. Box 5126, York, PA 17405-9792
(800) 233-1957, Fax: (717)747-7051
claims@glatfelters.com

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE

NOTE: Important State Information Included

DATE OF THIS REPORT _____

SECTION 1 – CLAIMANT INFORMATION

To be completed by the injured person, or next of kin if the claimant is unable or a fatality has occurred.

Home Phone (___) _____ Cell Phone (___) _____ Work Phone (___) _____

Name _____ Soc. Sec. No. _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Weight _____ Height _____

Gender _____ Marital Status _____ Name of Spouse (if applicable) _____

Date of Incident or Organization's Activity _____ Year _____ Time _____ ☐ AM ☐ PM

Full-Time/Regular Occupation _____ Annual Income _____

Name/Address of Full-time Employer _____

Length of Employment in this Work _____ Employer's Phone Number _____

SECTION 2 – INCIDENT AND MEDICAL TREATMENT INFORMATION

1. What activity was the individual above involved in at the time of their injury or illness?

_____

2. How did the injury or illness occur?

_____

3. Please describe the injury or illness.

_____

4. Date of first day of full-time occupation missed due to above injury or illness (if applicable) _____ N/A ☐
5. Date able to return to work (if applicable) _____ N/A ☐
6. Attending Physician's Name, Address and Telephone Number _____
7. Name and Address of Hospital _____
8. Date Hospitalized From _____ To _____

SECTION 3 – AUTHORIZATION TO DOCTOR, HOSPITAL, CLINIC, EMPLOYER, INSURANCE COMPANY OR WORKERS' COMPENSATION CARRIER TO RELEASE MEDICAL INFORMATION

I authorize any Health Care Provider, Employer, Insurance Company, Workers' Compensation Carrier, Person or Organization to release information regarding my medical history, treatment, earnings, or benefits payable, including disability or employment related information, to Glatfelter Claims Management Inc., for the purpose of determining benefits that may be payable under the VFIS Accident and Sickness (A&S) policy. If medical benefits are determined to be payable under the VFIS A&S policy, I authorize payment to be made directly to my medical provider(s). A photocopy or digital copy of this authorization is valid in place of the form containing my original signature. This authorization shall be valid for the duration of my claim.

Signature of Injured Member or Next of Kin _____ Relationship _____ Date _____

SECTION 4 – CERTIFICATION

To be completed by official of named insured organization (must be other than injured person)

- Was the injured person a member of your organization at the time of the above described incident? ☐ Yes ☐ No
- If claimant is a member of organization, please select type of member: ☐ Junior ☐ Adult ☐ Auxiliary
- Was the activity described in #1 above an authorized activity of the named insured organization? ☐ Yes ☐ No
- **Name and Address of Organization**

HANOVER TOWNSHIP FIRE DISTRICT NO. 3
PO BOX 511
CEDAR KNOLLS, NEW JERSEY 07927-0511

- Policy Number _____
- Organization Telephone Number **(973) 267-5659**
- Home Telephone Number of Official Signing Below _____

I certify that the above is true.

Signed _____ Title _____ Date _____

Print Name _____

Fraud Warning

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in Arizona

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in California

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Applicable in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in Pennsylvania

WARNING: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Applicable in Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in All Other States

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax # (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: SEE ENCLOSED SHEET FOR IMPORTANT STATE INFORMATION.

Name of Patient _____ DOB _____

Address _____ Telephone _____

Regular Occupation _____

Name of Insured Organization _____ Policy No. _____

IMPORTANT

Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature _____
Insured Member Patient

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

The above named individual has filed a claim for benefits as a result of the Injury/Illness for which he/she is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us.

(1) Diagnosis and concurrent conditions (If fracture or dislocation, describe nature and location, If Sickness / Illness describe nature).

(2A) When did symptoms first appear or accident happen? Date _____

(B) When did patient consult you for this condition? Date _____

(C) Has patient ever had same or similar condition? (If Yes, state when and describe) ☐ Yes ☐ No

(3A) Nature of surgical procedure, If Any (Describe Fully) - Date Performed _____ ☐ Inpatient ☐ Outpatient

(B) If performed in hospital, give name and address:

(4) What other services, If any, did you provide patient?

(5) Is patient still under your care for this condition? ☐ Yes ☐ No
If "No" give date your services terminated. _____ Date _____

(6A) How long was or will patient be continuously totally disabled due to diagnosis in #1 above?
(Unable to perform Regular Occupation) From Date _____ Through _____

(B) How long was or will patient be partially disabled? From Date _____ Through _____

(C) Approximate date patient will return to work if still disabled Date _____

(7) Restrictions:

Date _____ Signature _____
(attending physician) (degree) (telephone no.)

Address _____

VFIS®
A Division of Glatfelter Insurance Group

Please Note: This report is intended to be used by Emergency Service Organizations for internal use only. It is not an acceptable VFIS Claims form and therefore should not be submitted to VFIS.

Personal Injury/Illness Investigation Report

Emergency Service Organization_____ Date_____

Address_____

Name of Injured_____ Date of Birth_____

Address of Injured_____

Phone( )_____ Age_____ Sex_____ Height_____ Weight_____

Occupation_____ Job Title_____

Social Security Number_____ Years with Dept._____

Date of Injury_____ Time of Injury_____

Date Reported_____ Time Reported_____

Accident Reported To_____

Nature of Injury

- ☐ Fractures
- ☐ Inflammation
- ☐ Infectious Disease
- ☐ Frostbite, Cold Exposure
- ☐ Pinched Nerve, Ruptured Disk
- ☐ Electric Shock
- ☐ Chemical Injury
- ☐ Multiple Injury
- ☐ Recurrence
- ☐ Strain, Sprain, Torn Ligament
- ☐ Cuts, Lacerations, Punctures
- ☐ Inhalation, Fumes
- ☐ Inhalation, Smoke
- ☐ Heat Exhaustion, Fatigue
- ☐ Abrasions, Contusions, Bruises
- ☐ Heart Malfunction
- ☐ Eye Injury
- ☐ Burns
- ☐ Other _____

Parts of Body Affected

- ☐ Multiple Parts
- ☐ Head
- ☐ Eye(s)
- ☐ Ear(s)
- ☐ Neck
- ☐ Shoulder
- ☐ Chest
- ☐ Lung
- ☐ Abdomen
- ☐ Back
- ☐ Heart
- ☐ Groin
- ☐ Arm
- ☐ Hand
- ☐ Finger
- ☐ Leg(s)
- ☐ Knee(s)
- ☐ Ankle(s)
- ☐ Foot/Feet
- ☐ Ribs
- ☐ Hip
- ☐ Other _____

Where Injury Occurred

- ☐ Station Maintenance
- ☐ Apparatus Maintenance
- ☐ Emergency Scene
- ☐ Private Auto to Emergency
- ☐ Private Auto Non-Emergency
- ☐ Fundraising
- ☐ Convention
- ☐ Emergency Vehicle to Emergency
- ☐ Emergency Vehicle Non-Emergency
- ☐ Parades, Picnics, Contests
- ☐ Standing By Station for Call
- ☐ Training
- ☐ Auxiliary Services
- ☐ Responding/Returning to Emergency (Non-Vehicle)
- ☐ Other _____

Cause of Injury

- ☐ Fall
- ☐ Weather
- ☐ Making Safety Devices Inoperative
- ☐ Using Defective Equipment
- ☐ Using Equipment Improperly
- ☐ Failure to Use Personal Protection Equipment
- ☐ Struck By Object
- ☐ Improper Lifting
- ☐ Horseplay
- ☐ Structural Collapse
- ☐ Inadequate Guards or Protection
- ☐ Back Draft
- ☐ Improper Placement
- ☐ Civil Disturbance
- ☐ Inadequate Illumination
- ☐ Inadequate Ventilation
- ☐ Lack of Knowledge or Skill
- ☐ Irrational Civilian
- ☐ Communication
- ☐ Abuse or Misuse
- ☐ Other _____

Injury Occurred - Performing What Task?

- ☐ Forcible Entry
- ☐ Using Ladders
- ☐ Advancing/Directing Hose Line
- ☐ Ventilating
- ☐ Overhauling
- ☐ Salvage
- ☐ Servicing/Repairing Equipment
- ☐ Extrication
- ☐ Rescue Operation
- ☐ Administering Medical Aid
- ☐ Physical Fitness
- ☐ Other _____

Witness(es) to Injury: _____

Injured Person's Signature_____ Date_____

Investigation Report

Thoroughly describe accident: (What, How, Where, Equipment, Activity, etc.) _____

_____

_____

_____

_____

_____

Hospitalized or Treated, Where? (Include Address)_____

_____

Name and Address of Physician: (Include Referral)_____

_____

Did the injury require individual to perform limited duties, or to be assigned to other duties or positions? YES or NO If yes, what duties or position? _____

And, what period of time? _____

Investigated by _____ Title _____ Date _____

Safety Officer's Report

What Acts, Failures to Act and/or Conditions Contributed Most Directly to This Accident? (Immediate Cause)

_____

_____

_____

What Are the Basic or Fundamental Reasons for the Existence of These Acts and/or Conditions? (Fundamental Cause)

_____

_____

_____

What Action Has or Will Be Taken to Prevent Recurrence? Place "X" By Items Completed.

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed by Safety Officer_____ Title _____ Date _____