Workers Comp Reporting for Town Employees and Volunteer Firefighters

1. Call 1-800-293-9795 to make initial verbal report (which will be faxed to the Town Clerk)

2. If injury is a threat to life or limb go to nearest emergency room. If the injury is not a threat to life or limb, please visit Atlanticare Urgent Care in Hammonton or Atlanticare Occupational Medicine in Egg Harbor Twp. It's the decision of the injured person as to where they feel they need to seek treatment.

3. If injury requires follow up treatment, you must first make an appointment with the below to be referred:

Atlantic Care Occupational Medicine-Town Doctor
2500 English Creek Ave.
Suite 908
Egg Harbor Twp, NJ
(609) 677-7200

4. Always have current photo identification and the below billing information with you when visiting doctors. Also, you or your provider may use the below information for submitting worker comp bills to the Town of Hammonton insurance company. Be sure to complete the necessary information about yourself so your bill will be paid promptly.

TOWN OF HAMMONTON
EMPLOYEE WORKER COMP INJURY / ILLNESS
BILLING FORM / DIRECTIONS

Dear Medical Provider:

The attached bill from your office was received by the Town of Hammonton and/or the injured employee who was treated by you. However, the attached bill for this injury or illness was work related and should be billed to:

CSG/CHN PPO
Consolidated Services Group Inc.
300 American Metro Blvd.
Suite 170
Hamilton, NJ 08619
Phone 1-800-293-9795

Please include this form with your bill and the following information:
Name of Employee(s) : _____
Employees Social Security Number: _____
Employees date of injury: _____

If you have not received payment in a timely manner, please follow up with billing questions to CSG at 1-800-293-9795.

Very truly yours,
April Boyer Maimone
Municipal Clerk

5. Please have your department head complete attached Report of Accident and submit to the Town Clerk office.

SUPERVISOR'S REPORT OF ACCIDENT

Name of Location: _____ Date of Report: _____ Claim No: _____ Date Supervisor Informed: _____

The only way to prevent accidents is to **FIND** and **REMOVE** accident causes.
There is always some cause for an accident (unsafe act, unsafe conditions, or both).

NAME OF INJURED EMPLOYEE: _____ SOCIAL SECURITY NO.: _____

JOB TITLE: _____ DEPARTMENT: _____ SEX: F ____ M ____ DATE OF BIRTH: _____

LENGTH OF EMPLOYMENT: DATE OF HIRE _____ IN THE DEPT. _____ SUPERVISOR _____

PREVIOUS HISTORY: _____

PHYSICAL DISABILITIES _____

DATE OF INJURY: _____ HOUR: ____AM ____ PM ____ DEPT. WHERE INJURED: _____

EXACT LOCATION: _____

WITNESSES: _____

TREATMENT: 1. ☐ FIRST AID 2. ☐ NURSE 3. ☐ DOCTOR 4. ☐ HOSPITAL 5. ☐ OTHER THAN FIRST AID, DUE TO DELAYED MEDICAL TREATMENT

DAYS LOST: YES ☐ NO ☐ ESTIMATED NO. _____

MARK APPROPRIATE DESCRIPTION WITH AN "X"

NATURE OF INJURY

1. ☐ CUT
2. ☐ BRUISES AND CONTUSIONS
3. ☐ STRAIN OR SPRAIN
4. ☐ FRACTURE
5. ☐ BURN (HEAT)
6. ☐ BURN (CHEMICAL)
7. ☐ FRACTURE
8. ☐ AMPUTATION
9. ☐ PUNCTURE
10. ☐ HERNIA
11. ☐ GANGLION
12. ☐ ABRASIONS
13. ☐ DERMATITIS
14. ☐ IRRITATION
15. ☐ POISONING (INCLUDING INSECT & REPTILE BITES)
16. ☐ ASPHYXIA
17. ☐ CONCUSSION
18. ☐ DISLOCATION
19. ☐ ELECTRIC SHOCK
20. ☐ HEARING LOSS
21. ☐ HEAT EXHAUSTION
22. ☐ MULTIPLE
23. ☐ FREEZING
24. ☐ OTHER

BODY PART

HEAD & NECK
1. ☐ HEAD
2. ☐ SCALP-SKULL
3. ☐ EYES
4. ☐ EARS
5. ☐ NOSE
6. ☐ FACE
7. ☐ MOUTH-TEETH
8. ☐ JAW
9. ☐ NECK
10. ☐ BRAIN

UPPER EXTREMITIES
11. ☐ SHOULDER
12. ☐ UPPER ARM
13. ☐ ELBOW
14. ☐ FOREARM
15. ☐ WRIST
16. ☐ HAND
17. ☐ FINGERS & THUMBS
18. ☐ MULTIPLE-UPPER EXTREMITIES

BODY
19. ☐ BACK
20. ☐ CHEST-INCLUDING INTERNAL ORGANS
21. ☐ ABDOMEN-INCLUDING INTERNAL ORGANS
22. ☐ GROIN
23. ☐ BODY-MULTIPLE

LOWER EXTREMITIES
24. ☐ HIPS
25. ☐ THIGH
26. ☐ KNEE
27. ☐ LOWER LEG
28. ☐ ANKLE
29. ☐ FEET
30. ☐ TOES
31. ☐ MULTIPLE-LOWER EXTREMITIES
32. ☐ OTHER
33. ☐ MULTIPLE PARTS

ACCIDENT TYPE

1. ☐ CONTACT WITH
2. ☐ CAUGHT IN
3. ☐ CAUGHT BETWEEN
4. ☐ CAUGHT BY
5. ☐ STRUCK AGAINST (ROUGH OR SHARP OBJECTS, SURFACE, ETC. EXCLUSIVE OF FALLS)
7. ☐ STRUCK BY FALLING OBJECT
8. ☐ STRUCK BY SLIDING, ROLLING OR OTHER MOVING OBJECTS
9. ☐ INHALATION, INGESTION, ETC.
10. ☐ FALL ON SAME LEVEL
11. ☐ FALL TO DIFFERENT LEVEL
12. ☐ SLIP (NOT A FALL)
13. ☐ UPSET
14. ☐ LIFTING
15. ☐ OVEREXERTION
16. ☐ HANDLING
17. ☐ EXPLOSION
18. ☐ OTHER

AGENCY OF ACCIDENT

1. ☐ MACHINE
2. ☐ VEHICLE
3. ☐ HAND TOOLS
4. ☐ FOREIGN BODY
5. ☐ CHEMICALS
6. ☐ LADDER OR SCAFFOLD
7. ☐ ELECTRICAL APPARATUS
8. ☐ BOILERS & PRESSURE VESSELS
9. ☐ FLOORS OR LEVEL SURFACES
10. ☐ STAIRS, STEPS, OR PLATFORMS
11. ☐ BUILDING (DOOR, PILLAR WALL, WINDOW, ETC.)
12. ☐ MANLIFT
13. ☐ ELEVATORS (PASSENGER AND FREIGHT)
14. ☐ HOIST AND CRANES
15. ☐ CONVEYORS (CHUTES, BELTS, GRAVITY)
16. ☐ MATERIAL HANDLED (PAPER, ROLLS, ETC.)
17. ☐ PALLETS
18. ☐ HOT MATERIAL
19. ☐ WELDING EQUIPMENT
20. ☐ OTHER

DESCRIBE ACCIDENT: (INCLUDE THE MACHINE, OBJECT, OR SUBSTANCE INVOLVED – ALL DETAILS. USE ATTACHED SHEET, IF NECESSARY)

MARK BASIC CAUSE WITH AN "X" AND CONTRIBUTING CAUSES, IF ANY, WITH AN "O"

UNSAFE ACT:

1. ☐ VIOLATION OF A SAFETY RULE
2. ☐ HORSEPLAY, DISTRACTING, TEASING
3. ☐ FAILURE TO USE PERSONAL PROTECTIVE DEVICES
4. ☐ OPERATING WITHOUT AUTHORITY
5. ☐ OPERATING AT UNSAFE SPEED
6. ☐ USING DEFECTIVE EQUIPMENT
7. ☐ USING EQUIPMENT, TOOLS, ETC. UNSAFELY
8. ☐ UNSAFE HANDLING (LIFTING, CARRYING, ETC.)
9. ☐ MAKE SAFETY DEVICES INOPERATIVE
10. ☐ FAILURE TO WARN OR SECURE
11. ☐ WORKING ON MOVING EQUIPMENT
12. ☐ POOR HOUSEKEEPING
13. ☐ OTHERS

☐ NO UNSAFE ACTS

UNSAFE CONDITIONS:

1. ☐ INADEQUATELY GUARDED
2. ☐ UNGUARDED
3. ☐ GUARD NOT REPLACED
4. ☐ DEFECTIVE TOOLS, EQUIPMENT, OR SUBSTANCE
5. ☐ UNSAFE DESIGN OR CONSTRUCTION
6. ☐ HAZARDOUS ARRANGEMENT
7. ☐ IMPROPER ILLUMINATION
8. ☐ IMPROPER VENTILATION
9. ☐ IMPROPER DRESS
10. ☐ CONGESTED AREA
11. ☐ CLIMATE (WINDBLOWN OBJECTS)
12. ☐ POOR HOUSEKEEPING
13. ☐ OTHERS

☐ NO UNSAFE CONDITIONS

OTHER CONTRIBUTING FACTORS:

1. ☐ FAILURE TO FOLLOW DIRECTIONS
2. ☐ LACK OF KNOWLEDGE OR SKILL
3. ☐ FAILURE TO GET PROMPT MEDICAL ATTENTION
4. ☐ ACT OF OTHER THAN INJURED
5. ☐ BODILY DEFECT
6. ☐ OTHERS

WHY WAS THE UNSAFE ACT COMMITTED? (INADEQUATE TRAINING, HASTE, ETC.): _____

WHY DID THE UNSAFE CONDITION EXIST? (POOR WORK HABITS, ETC.): _____

BASED ON THE CAUSE CHECKED, INDICATE BELOW ACTION YOU ARE TAKING:

UNSAFE ACTS:

1. ☐ STOP THE WORKER
2. ☐ STUDY THE JOB
3. ☐ INSTRUCT (TELL-SHOW-TRY-CHECK)
4. ☐ FOLLOW-UP
5. ☐ ENFORCE
6. ☐ OTHER (INDICATE)

UNSAFE CONDITIONS:

1. ☐ REMOVE 2. ☐ GUARD 3. ☐ WARN
4. ☐ IF SUPERVISOR CAN'T HANDLE, THEN RECOMMENDED TO:
   - A. ☐ OWN SUPERVISOR
   - B. ☐ SAFETY COMMITTEE
   - C. ☐ MAINTENANCE DEPARTMENT
   - D. ☐ OTHER (INDICATE)
5. ☐ FOLLOW-UP

EVALUATION

LOSS SEVERITY POTENTIAL: ☐ MAJOR ☐ SERIOUS ☐ MINOR

PROBABLE RECURRENCE RATE: ☐ FREQUENT ☐ OCCASIONAL ☐ RARE

WHAT COULD YOU HAVE DONE TO HAVE PREVENTED THIS ACCIDENT? _____

WHAT ARE YOU ACTUALLY DOING TO PREVENT A SIMILAR ACCIDENT? _____

IMMEDIATE SUPERVISOR: _____ SAFETY REPRESENTATIVE: _____

INJURED EMPLOYEE: _____ SUPERINTENDENT: _____

SAFETY OFFICE – FILL OUT COMPLETELY

HOME ADDRESS: _____ ZIP CODE: _____ TELEPHONE: _____

PHYSICIAN: _____ ADDRESS: _____ ZIP CODE: _____ TELEPHONE: _____

HOSPITAL: _____ ADDRESS: _____ ZIP CODE: _____ TELEPHONE: _____

TOTAL DAYS LOST: _____ THIS ACCIDENT WAS PRIMARILY A RESULT OF AN UNSAFE ACT _____ UNSAFE CONDITION _____