Must be completed and sent to
CCM Human Resources, HH 106, within 24 hours

Attachment B
(Two sided)
(Rev. 8/18)

MORRIS COUNTY WORKERS' COMPENSATION REPORT OF INJURY

ACCIDENT REPORT OF INJURY TO EMPLOYEE & SUPERVISOR ACCIDENT INVESTIGATION

ALL ACCIDENTS, REGARDLESS OF SEVERITY, MUST BE REPORTED IMMEDIATELY TO QUAL LYNX., AT **1-800-425-3222** (INCLUDING DAYS, NIGHTS, WEEKENDS AND HOLIDAYS). THIS REPORT MUST BE COMPLETED AND SIGNED BY THE EMPLOYEE AND SUPERVISOR AS SOON AS POSSIBLE AND FAXED TO **973-328-5067**. IF EMPLOYEE IS UNABLE TO COMPLETE AT THE TIME OF THE INCIDENT, THEY MUST COMPLETE AND SIGN AS SOON AS POSSIBLE. ANY FALSE STATEMENTS MADE ON THIS DOCUMENT MAY RESULT IN DISCIPLINARY ACTION INCLUDING TERMINATION.

1. EMPLOYEE NAME			2. JOB TITLE	
3. HOME ADDRESS STREET	TOWN	STATE	ZIP	HOME PHONE
4. DEPARTMENT & WORK LOCATION		5. DATE HIRED	6. GENDER ( ) MALE ( ) FEMALE	7. SOCIAL SECURITY NO.
8. D.O.B.	9. EMPLOYMENT STATUS ( ) FULL TIME HOURS PER WEEK_____ ( ) PART TIME SHIFT_____	10. REGULAR DAYS OFF	11. MARITAL STATUS ( ) SINGLE ( ) MARRIED	12. # OF DEPENDENTS
13. DATE OF ACCIDENT	14. DAY OF ACCIDENT	15. TIME OF ACCIDENT	16. DATE REPORTED TO SUPERVISOR	17. WERE YOU ABLE TO RETURN TO WORK? ( ) YES ( ) NO
18. LOCATION OF ACCIDENT BLDG./RM #/LOT #/ETC. FACILITY_____, CCM		19. IF MOTOR VEHICLE ACCIDENT: WAS VEHICLE DAMAGED ( ) YES ( ) NO DID OTHERS CLAIM INJURY ( ) YES ( ) NO # OTHERS INJURED_____		

20. WITNESSES
NAME AND ADDRESS — EMPLOYEE

_____ ( ) YES ( ) NO

_____ ( ) YES ( ) NO

21. HAVE YOU HAD ANY PREVIOUS INJURIES OF THIS NATURE? ( ) YES ( ) NO

GIVE DETAILS, DATE, AND TREATING DOCTOR'S NAME:_____

_____

22. DETAILS OF HOW ACCIDENT OCCURRED: _____

_____

WHAT JOB DUTIES WERE YOU PERFORMING? _____

WHAT PART OF YOUR BODY WAS INJURED? _____

DESCRIBE SEVERITY AND EXTENSIVENESS OF INJURY: _____

_____

WHAT DO YOU THINK CAUSED THIS ACCIDENT? _____

_____

DO YOU WISH MEDICAL ATTENTION AT THIS TIME? ( ) YES ( ) NO

HAVE YOU GONE TO A COUNTY-APPROVED MEDICAL FACILITY? ( ) YES ( ) NO WHICH ONE?_____

23. **STATEMENT OF FACT, AUTHORIZATION TO FURNISH MEDICAL INFORMATION, AND WORK RESTRICTIONS**

YOU ARE HEREBY REQUESTED AND AUTHORIZED TO DISCLOSE, MAKE AVAILABLE AND FURNISH TO THE COUNTY OF MORRIS OR ANY AUTHORIZED REPRESENTATIVE, ALL INFORMATION, RECORDS, X-RAYS, REPORTS OR COPIES THEREOF RELATING TO ANY MEDICAL EXAMINATION, CONSULTATION, CONFINEMENT OR TREATMENT AND TO PERMIT THEM TO INSPECT AND MAKE COPIES OR ABSTRACTS THEREOF. YOU ARE ALSO AUTHORIZED TO SEND ANY DRUG/OR ALCOHOL INFORMATION IF APPLICABLE. I HEREBY CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE, AND I AM AWARE THAT IF ANY STATEMENT MADE HEREIN IS WILLFULLY FALSE THAT I AM SUBJECT TO PUNISHMENT AS PROVIDED BY LAW. I UNDERSTAND THAT ONLY TREATMENT AUTHORIZED BY MORRIS COUNTY WILL BE PAID BY MORRIS COUNTY. I WILL BE RESPONSIBLE FOR PAYMENT OF ALL TREATMENTS NOT AUTHORIZED BY MORRIS COUNTY. I ALSO UNDERSTAND THAT WHILE RECEIVING WORKER'S COMPENSATION BENEFITS, I AM NOT PERMITTED TO PERFORM ANY TYPE OF WORK FOR REMUNERATION OR PROFIT WITHOUT FIRST NOTIFYING THE OFFICE OF RISK MANAGEMENT. I AM ALSO NOT PERMITTED TO PERFORM ANY TYPE OF ACTIVITY, VOLUNTEER OR OTHERWISE, WHICH MAY AGGRAVATE OR RETARD THE HEALING PROCESS. (EXAMPLE: TRAVELING, CHORES, YARD WORK, PAINTING, SHOVELING SNOW, SPORTS, AND VOLUNTEER FIRE / OR FIRST AID SQUAD.)

_____
SIGNATURE OF EMPLOYEE (DATE)

24. SIGNED-PERSON IN DIRECT CHARGE OF WORK	TITLE	PHONE #:	DATE
25. APPROVED-PERSON IN GENERAL CHARGE OF WORK	TITLE	PHONE #:	DATE

SUPERVISOR'S INJURY/ILLNESS INVESTIGATION REPORT

(TO BE FILLED OUT BY EMPLOYEE'S SUPERVISOR)

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Injured/Ill Employee's Name: _____ **Injury Date:** _____ **Injury Time:** _____

Department: **Position Title:**

1. What did you observe at the location where the injury/illness occurred? _____

2. What activity was the employee performing at time of injury/illness? _____

3. Was this activity part of the employee's job responsibilities? If no, explain. _____

4. Was the activity being done according to instruction or standard procedures? _____

5. What personal protective equipment is required to perform this task? _____

5a. Were all safety procedures followed, including wearing required personal protective equipment?

6. Did you find all equipment involved to be in good working order? _____

IF ANY IMPLEMENT, TOOL, PIECE OF MACHINERY OR OTHER OBJECT WAS THE CAUSE OF, OR WAS IN ANY WAY CONNECTED WITH THE ACCIDENT, IT SHOULD BE INSPECTED IMMEDIATELY. IF OBJECT IS PORTABLE, AND UNLESS ITS CONTINUED USE IS ABSOLUTELY NECESSARY, IT SHOULD BE PLAINLY LABELED AND PLACED IN THE CARE OF THE PERSON IN AUTHORITY. A REPORT OF ANY INSPECTION AND A NOTICE OF THE WHEREABOUTS OF THE OBJECT SHOULD BE SENT WITH THIS REPORT.

7. After review of these responses, and investigation of the location where the injury/illness occurred, what in your opinion caused this injury/illness?_____ _____

8. If you answered NO to any questions above, please state corrective action taken to address the questions to which you responded NO.

ALL QUESTIONS MUST BE ANSWERED OR THIS FORM WILL BE RETURNED TO YOUR DEPARTMENT DIRECTOR

Name of Supervisor: _____ **Signature of Supervisor:** _____

Name of Division Head/ Department Head: _____ **Signature of Division Head/Department Head:** _____

Date of this report:

THE SIGNATURES OF IMMEDIATE SUPERVISOR AND DIVISION HEAD/ DEPARTMENT HEAD ARE REQUIRED

SEND **ORIGINAL TO CCM HR TO BE FORWARDED TO MORRIS COUNTY RISK MANAGEMENT**
COPY TO EMPLOYEE FILE