# ACCIDENT INVESTIGATION REPORT

(Immediate completion of this form will help us to assist employees in obtaining Workers Compensation benefits and help us to prevent future injuries to others)

Insured: Township of North Brunswick _____ Today's date: _____
Department: _____ Time: _____

**PART I** **Employee must complete and answer all questions**

Name: _____ Date of Birth _____

Home address: _____

Home Telephone: _____ Sex: ☐ M ☐ F Marital Status: _____

Your Usual Occupation: _____ Date Hired: _____

Date of Accident: _____ Time of Accident: _____ ☐ am ☐ pm

Exact Location Where Accident Occurred: _____

Occupation at Time of Accident: _____ On Employer's Premises? ☐ Yes ☐ No

Employee's Complete Description of Accident ( Give details in explaining what happened): _____

_____

_____

Description of Injury (Give details including part of body injured): _____

_____

_____

Did anyone witness this accident? ☐ Yes ☐ No If yes, name of all witnesses: _____

_____

_____ _____

Employee Signature Social Security Number

**SHOULD BE COMPLETED BY EMPLOYEE'S DIRECT SUPERVISOR**

**Part II To Be Completed By Supervisors to Whom Accident Reported- Report All Hazards Immediately!**

Supervisor's Name & Title : _____

1. Do you usually supervise this individual? ☐ Yes ☐ No* (Explain Below) For How Long _____
2. Was accident immediately reported? ☐ Yes ☐ No* (Explain Below) (If no, when and how did you learn of the accident?)
3. Was employee working ☐ Alone* (Explain Below) ☐ With crew or fellow workers?
4. Was employee at work and on company time? ☐ Yes ☐ No* (Explain Below)
5. Did you physically inspect the area where injury occurred? ☐ Yes ☐ No* Explain Below)
6. Any unsafe conditions or unusual hazards present? ☐ Yes* ☐ No
7. Evidence of Horseplay? ☐ Yes* ☐ No
8. Evidence of intoxication? ☐ Yes* ☐ No
9. Evidence of drug abuse? ☐ Yes* ☐ No
10. Was employer provided safely equipment in use? ☐ Yes ☐ No*
11. Was immediate medical attention necessary? ☐ Yes ☐ No If yes, Where? _____
    By Whom? _____
12. Is employee at work now? ☐ Yes ☐ No If no, when do you expect the employee to Return? _____
    If Yes, ☐Full Duty ☐ Light Duty
13. Are you satisfied that the accident/injury occurred as described above? ☐ Yes ☐ No*
14. Do you feel that accidents such as this can be avoided in the future? ☐ Yes* ☐ No
15. Describe action(s) taken to prevent recurrence (safety talk with employees, eliminate unsafe practice, remove hazards, etc)

_____

_____

16. Do you want to discuss this matter with the claims representative? ☐ Yes* ☐ No

Explain all * items by number on an attached sheet.

Prepared by: _____ Dept: _____ Date: _____
Signature Phone: _____

**FORM TO BE COMPLETED AS SOON AS POSSIBLE AFTER ACCIDENT**

# AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

## PATIENT INFORMATION

*(please print)*

Patient Name: _____ DOB : _____

Patient Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize: _____

*(Name of physician's office/medical practice disclosing information)*

## REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to:

Qual-Lynx/Scibal Associates Inc. Phone: 908-222-7500
PO Box 1209 /30 Knightsbridge Road Fax: 908-222-2299
Piscataway, NJ 08854

Please indicate the infonnation or types of information to be disclosed: any and all medical records in your possession, including but not limited to any and all office notes, medical records, reports, diagnostic studies, hospital records, operative reports, psychiatric and /or psychological records, bills etc.

Specify dates (or date range) if applicable:

This request is for the purpose of investigation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in two years or on the following date:_____

I understand that any disclosure of information may be subject to re-disclosures by the recipient and may no longer be protected by federal state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.
IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE_____

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

A copy of this signed form will be provided to the claimant patient.
Photocopies of this Authorization carry the same authority as the original.

_____ _____
Signature of Patient of Authorized Representative Date

_____ _____
Description of Representative's Authority Signature of Witness
(witness signature required)

File # _____