Board of Cooperative Educational Services of Nassau County
71 Clinton Road, P.O. Box 9195
Garden City, NY 11530-9195

OFFICE USE ONLY
Case #: _____
AWW:_____

Employer's Injury/Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the Confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

EMPID # _____
SCHOOL YR _____

SECTION 1

Injured Employee (To be filled out by Employee or Supervisor) Submit this report within 24 hours of incident

Note: If employee is unable to sign report due to injury severity, report should be submitted without employee's signature.

Last Name_____ First Name_____ Male ___ Female ___

Home Address (#, Street, City, Zip Code) _____ Telephone # _____

Social Security # ___/___/___ Date of Birth ___/___/___ Date of Hire ___/___/___

Department and Program Name _____ Job Title _____

Address where injury/incident occurred (Name of building, address, town) _____ Is this the employee's regular work location? _____ Where at the location did the incident occur?(gym, parking lot, field trip, etc.) _____

By law, in cases of work-related illness or injury, incidents are recorded on the *"Log of Work-Related Injuries and Illnesses",* which may be released to employees, former employees, their personal representatives and authorized employee representatives without further notice.
ILLNESS CASES ONLY (Not Injury Cases) ☐ Check this box if the employee independently and voluntarily requests that his or her name not be entered on the log. If checked, treat as a privacy concern case.

Employee Signaure_____

SECTION 2

Date of Incident ___/___/___ Day of Week _____ Time of Incident _____AM / PM Time Employee Began Work _____AM / PM

Date Incident Reported to Supervisor ___/___/___ If employee died, when did death occur? ___/___/___

Witness(es) _____ Safety devices in use (gloves, safety glasses, shoes, etc.) _____

a. Description of injury/incident and Cause
(To be filled out by Employee's Supervisor)

(Attach sheets with additional information, if warranted)

What was the employee doing just before the incident occurred? (sequence of events); Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Example*: **"The employee states** that he was climbing a ladder while carrying roofing materials."

What happened? Tell how the injury occurred. *Example*: "**The employee states** that when the ladder slipped on wet floor, he fell 20 feet."

What object or substance directly harmed the employee? *Example*: "concrete floor".

b. Corrective Action
(To be filled out by Employee's Supervisor)

What corrective actions have been taken or need to be taken to prevent similar future incidents?

* Any prior accidents? _____ Dates? _____ Is this a recurrence of an injury?_____

c. Nature of Injury
(To be filled out by School Nurse or Supervisor)

☐ Recorded on SH-900

Nature of Injury. Be Specific: (abrasion, bruise, strain, cut, scratch, bite, fracture, burn, poisoning, puncture, respiratory condition, insect/animal bite etc.)

Parts of body involved (indicate right or left side)

Was this a Nasau BOCES student related injury? ☐ YES ☐ NO

What medical care was provided?
☐ None
☐ First Aid
☐ Other (detail)

If medical care was provided, who was employee seen by?
☐ School Nurse
☐ Doctor
☐ Other (detail)

Date Seen __/___/__

Was employee treated in an emergency room? ☐ Yes ☐ No

Was employee hospitalized overnight? ☐ Yes ☐ No

Details of medical care _____ Name and address of physician/ school nurse/ health care professional/ treatment facility _____

SECTION 3

Authorized Signature
(To be filled out by Employee's Supervisor)

Signature of Supervisor _____ Supervisors Name **(PRINT)** _____ Date of this Report _____

If employee has not yet returned to work, have the injured person inform Human Resources when he or she returns to work. The telephone number is (516) 396-2269.

Board of Cooperative Educational Services of Nassau County
Department of Human Resources

IMPORTANT INSTRUCTIONS FOR COMPLETION OF FORM "EMPLOYER'S INJURY/INCIDENT REPORT"

Please read and complete the front and back before preparing the attached C-3 form. Use the checklist below.

__ The employee must report the incident to his/her supervisor immediately.

__ The employee should complete the "Leave Usage" section at the bottom of this page if he/she is NOT authorizing the use of his/her time and send it to Human Resources at 71 Clinton Road, P.O. Box 9195, Garden City, NY 115309195.

__ All absences associated with a work-related injury must be called into the sub-system as workers' compensation and must be marked on time sheets as "G" - workers' compensation.

__ The employee must sign Section 1. For illness cases only (not injury cases), the employee may choose to check the box indicating he/she wants the incident to be treated as a privacy concern case.

__ The employee's supervisor must complete Section 2a, 2b and Section 3. The school nurse or the employee's supervisor must complete Section 2c.

__ A signed copy must be given to the employee and a copy retained by the school nurse. All sections of the Injury/Incident Report should be filled out on the same day as the injury/incident. The completed form should be sent electronically to WorkersComp@nasboces.org as well as placed in interoffice mail on the same day as the incident to Human Resources, Nassau BOCES Administrative Center, 71 Clinton Road, P.O. Box 9195, Garden City, NY 11530-9195.

Instructions to Employee

Medical Bills: Nassau BOCES employees should **NOT** pay medical (hospital, physician, prescriptions, etc.) bills for work-related injuries/incidents. The injured employee or service provider should forward such bills to the State Insurance Fund, 8 Corporate Center Drive, Melville, NY 11747-3166. Nassau BOCES workers' compensation policy number is **4135166**. Use this number until a case number is generated (approximately two weeks). **DO NOT** forward medical bills to any other party. This will only delay the prompt payment to the treating physician. If additional follow-up visits are necessary, continue to send all bills to the above address.

Leave Usage

Workers' Compensation Insurance payments to employees do not cover an employee's full salary. Unless an injured employee indicates otherwise below, the employee's accrued sick, personal and vacation will be used in lieu of workers' compensation payments for lost days to enable the employee to receive full salary. Sick days will be used first, personal days next and then vacation days. If the employee is entitled to workers' compensation for lost days, upon Nassau BOCES receipt of workers' compensation reimbursement for lost days, the portion of sick, personal and vacation days used in lieu of workers' compensation that is equivalent to such reimbursement payment will be restored by BOCES to the employee. This arrangement does not affect payments for medical expenses and other compensable items. ***By law, the first five lost days will be charged to sick time*** and will be returned to the employee only upon reimbursement to Nassau BOCES by the insurer.

*In order to instruct the payroll office **NOT** to use sick, personal, and vacation days, this form must be received by the Nassau BOCES Human Resources Dept. at 71 Clinton Road, Garden City, NY 11530-9195, during the pay period in which the injury occurred.*

*I, _____ do **NOT** authorize the use of my accrued sick days, personal days and vacation*
(insert name)
days in lieu of workers' compensation days for my days absent from work due to my work-related injury on_____/____/_____. I understand that I will be placed on the workers' compensation payroll. As a result, I will NOT be receiving compensation from Nassau BOCES. Additionally, I will be responsible for paying the employee portion of my health benefits.

____/___/_____ _____ _____ _____-_____-_____

Date *Employee Signature* *Social Security #*

OPTUM®

PERMA

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits under New York regulations for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

Representatives are available to answer any questions you have about your pharmacy benefits. You may also contact the New York State Workers' Compensation board at general_information@wcb.ny.gov or by phone at 1-877-632-4996 or the Advocate for Injured Workers at 1-800-580-6665. You may also find further information on the web atwcb.ny.gov.

OPTUM®

PERMA

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PERMA
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID number for online adjudication of approved benefits for the injured worker.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-260

OPTUM®

PERMA

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales bajo las regulaciones de Nueva York, para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?

1-866-599-5426

Nuestros representantes están disponibles para responder cualquier pregunta que tenga sobre sus beneficios farmacéuticos. También puede comunicarse con el directorio del Programa de compensación por accidentes laborales de Nueva York a través de general_information@wcb.ny.gov o llamando al 1-877-632-4996 o con el Defensor de los trabajadores accidentados llamando al 1-800-580-6665. También puede encontrar más información en la web visitando wcb.ny.gov.

OPTUM®

PERMA

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PERMA
PORTADORA EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill benefit eligibility and obtain the ID number for online adjudication of approved benefits for the injured worker.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-260

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

_____ _____ _____ _____
Signature of Injured Employee Date Signature of Witness Date

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

Estado de Nueva York
JUNTA DE COMPENSACIÓN OBRERA

Aviso de Aceptación de Uso de Proveedor de Servicios o Red de Salud Recomendado por Patrono o Compañía de Seguros

Nombre Empleado Lesionado	Seguro Social Empleado Lesionado	Día de Accidente
Nombre y Dirección del Patrono		

Al Empleado Lesionado:

Para el tratamiento de su lesión o enfermedad relacionada con su trabajo, usted puede escoger cualquier médico, podiatra, quiropráctico o sicólogo (con referido de un médico autorizado) que esté autorizado por la Junta y que esté aceptando pacientes de la Junta de Compensación Obrera.

Usted debe firmar esta forma de consentimiento si decide escoger usar una "Red" o Proveedores que sean recomendados por su patrono o por el seguro ó permitir que su patrono seleccione un proveedor en su nombre. Usted puede, en cualquier momento en el futuro cambiar su proveedor de salud de compensación obrera.

_____	_____	_____	_____
Firma Empleado Lesionado	Fecha	Firma Testigo	Fecha

Nota: No es necesario que usted firme este documento, si su patrono (1) participa en la organización certificada de proveedor preferido (PPO) acuerdo bajo el Artículo 10 A de la ley de Compensación Obrera, o (2) participa en el programa piloto de de resolución de alternativas de disputa (ADR) bajo la sección 25(2-C) de la ley de Compensación Obrera. De acuerdo con estos programas establecidos por ley, excepto en situaciones de emergencia, usted deberá al menos inicialmente, recibir tratamiento por lesiones o enfermedad en el trabajo, de una red certificada o de un proveedor designado por su patrono.

Al Patrono:
El patrono deberá proveer al empleado lesionado antes mencionado con una copia de esta forma firmada y deberá conservar el original en los records del empleado, donde pueda ser inspeccionada por la Junta de Compensación Obrera en cualquier momento. Esta forma no deberá ser sometida a la Junta de Compensación Obrera, ni deberá ser procesada con anterioridad a la lesión o enfermedad del empleado.

La Junta de Compensación Obrera emplea y sirve a personas con impedimentos sin discriminar.

FAQ's
FOR ON-THE-JOB INJURIES

REPORT ALL INJURIES AS SOON AS POSSIBLE

Where may I seek medical attention outside of the workplace?

You may seek medical treatment from a physician who accepts Workers' Compensation insurance. Be sure to tell the physician it is an injury that occurred at work and confirm the practice accepts Workers' Compensation insurance.

Do all injuries automatically receive a case number?

Yes. Public Employer Risk Management Association, Inc. (PERMA) will generate a case number for each injury reported. DO NOT PAY ANY INVOICES for medical treatment for your on-the-job injury. Send or have the facility send all invoices directly to PERMA.

It is important to call the attendance system and enter workers' compensation (not sick) if you are out due to an injury (the injury date must be indicated on the time sheet.)

Contact by PERMA Case Analyst.

You may be contacted by a PERMA Case Analyst. Please return e-mails and/or phone calls as soon as possible.

ADDITIONAL INFORMATION:

To qualify for compensable and/or contract days, you must be certified by a physician to be medically unable to work due to your on-the-job injury for the days you are out.

Please note that 10-month employees who are in a collective bargaining unit are not eligible for any benefits during the summer months, as outlined in their contract.

<u>You must use your own accrued time for:</u>
Partial days (It's recommended that you make appointments before or after your work day)
Independent Medical Examinations
Workers' Compensation Board Hearings

You will need a return to work note if you are absent. Any accommodations or restrictions requested must be detailed on the return to work note.

Nassau BOCES
Department of Human Resources
71 Clinton Rd, PO Box 9195
Garden City, NY 11530-9195

Effective July 1, 2020 the Nassau BOCES workers' compensation insurance carrier is:

PUBLIC EMPLOYER RISK MANAGEMENT ASSOCIATION, INC. (PERMA)
POLICY #: WC 0001521-00
INSURER ID W861223
9 Cornell Road
Latham, NY 12110
Phone: 1-888-737-6269
Fax: 1-877-737-6232
www.perma.org

The PERMA billing address for healthcare providers is:

PERMA

C/O CorVel

PO Box 2270

Portland, Oregon 97208