BCCS ON-THE-JOB ACCIDENT REPORT

Policy # 22123863

Employee Info & Injury Section

Social Security Number: _____ **Date of Birth:** _____ **Sex:** ❑ Male ❑ Female

Name (print): _____

Home Address: _____ **City:** _____**Zip:** _____

Phone Number: _____

Date of Incident: _____ **Time of Incident:** _____ **Time Shift Began:** _____

Bldg name, address & room # of incident: _____

_____

State all parts of body and type of injuries involved: (e.g. bruised right elbow)

_____

Describe how incident occurred: (if a trip & fall please describe shoes worn)

_____

_____

Witness Name and Contact Number: _____

Incident was reported to: _____ **Date Reported:** _____

Do you require medical treatment for this injury?

❑ **No medical treatment at this time** ❑ **Treatment was/will be provided by:**

Name (facility or physician): _____

I, the injured employee, herein certify the information above is true and to best of my knowledge.

Employee's Signature: _____ **Date:** _____

Supervisor's Section

Supervisor Name (print): _____ **Work Phone #:** _____

Did the accident occur as described above? ❑ Yes ❑ No ❑ Unknown

What precaution measures have been taken to prevent future occurrences? _____

_____

_____

Supervisor's Signature: _____ **Date**: _____

Benefits Dept. Section

Date of Hire: _____ **Weekly Salary:** _____

Program: _____ **Job Title:** _____

Employment Type: ❑Full Time ❑Part Time ❑Regular ❑Temporary

Did employee lose time from work after date of injury? ❑ Yes ❑ No ❑ Unknown

How many accrued hours does employee have remaining? Sick_____ Vacation_____

❑ **First Aid/Medical Only** ❑ **Lost Time Filed Comp Case**

- **Important OSHA Requirement: Supervisors must fax (516) 686-4472 or email kdanzi@ahrc.org all On-The-Job Accident Reports to the Benefits Department within 24 Hours. Please complete to best of knowledge. If there is any missing info please send the form over regardless. Delays in reporting in a timely manner could result in OSHA fines.**

Revised 12/21/16

WORKERS' COMPENSATION TRANSMITTAL FORM

Dear Medical Provider:

This notice is to advise that you are treating a valuable employee that has reported an on-the-job injury.

Please note that, unless this employee requires medical attention beyond two visits, the accident will be considered a first-aid case and Friedlander will ensure payment to you. As such, a workers compensation insurance claim number is not required. All medical bills should be sent directly to the address listed below for payment. Please include on all correspondence policy number 22123863.

Friedlander Group Inc.
2500 Westchester Ave.
Purchase, NY 10577
Telephone: 914-694-6000
Fax: 914-694-6004

Please be aware that, should the employee lose time from work and/or require more extensive treatment, a claim will be filed with our Workers' Compensation carrier. Should this occur, the employee will be notified and given the pertinent claim information, including their claim number.

In the event that this person must lose time from work, we offer a modified duty program to assist your patient in the transition to full duty employment. Should it be necessary, we are able to accommodate many restrictions that you may believe necessary to ensure full recovery of this patient. These include modified hours, duties and availability to continue medical treatment. Understand that the objective remains to return this individual to Full Duty Employment

Thank you for your assistance in this matter and do not hesitate to call if you need any further information or verification.