

IRVINGTON TOWNSHIP
WORKERS' COMPENSATION PROCEDURE

WORKERS COMPENSATION CLAIMS

CONCENTRA MEDICAL CENTER: 375 McCarter Highway
Newark, NJ 07114
(973) 643-8601
M-F 7:00 am to 7:00 pm
(various additional locations)

EMERGENCY ROOM

Please follow the Workers' Compensation Procedures that follow when reporting to an Emergency Room due to injury. Please report to the closest Emergency Room.

NOTE: Employees must notify their Department Head and the Office of the Business Administrator within 24 hours of an Emergency Room visit (or the first day the Township is open for business following a Friday or weekend injury). A follow-up appointment must be scheduled with Concentra.

***FAILURE TO FOLLOW THE ABOVE PROCEDURES MAY RESULT
IN A REJECTION OF A WORKER'S COMPENSATION CLAIM.***

WORKER'S COMPENSATION PROTOCOL

The following procedures must be used for work-related injuries:

1. The employee should report the incident/injury to his/her immediate supervisor.
2. The employee should complete the Township Employee Accident Reporting Form and ensure a completed copy of same is faxed to D&H at (973)940-1852.
3. The employee should thereafter receive a referral form to present to the treating facility.
4. If the injury requires immediate medical attention and there is no supervisor available, the employee should contact the Office of the Business Administrator to report the issue at (973)399-6682 (during working hours).
5. Employees working on the evening shift or weekends should report to his/her immediate supervisor. In the event the supervisor is absent from work or otherwise unavailable, via telephone, the employee should report directly to the nearest emergency room and leave a voice mail message for his/her immediate supervisor regarding the injury. A return call will be made to verify information on the next working day.
6. After the employee has been treated for the medical emergency, further treatment must be authorized by Concentra. Each work related injury will be evaluated to assure that the employee receives optimum care. If the employee needs to see a specialist, a referral will be made by Concentra upon completion of the evaluation.

All employees must follow the above procedures concerning the treatment for a work-related injury, in order to qualify for workers compensation benefits. If these procedures are not followed, all medical treatment and lost time can be denied. Thank you.

IRVINGTON TOWNSHIP
EMPLOYEE ACCIDENT INJURY REPORT

This form MUST be completed as close to the accident/injury occurrence as possible.

Date of Injury: _____ Time of Injury: _____ AM ___ PM ___ Location of Injury: _____

Name _____ Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone No.: _____

Cell No.: _____ Date of Birth: _____ Social Security No.: _____

Date of Hire: _____ Position: _____ Work Location: _____

Witnesses to the Injury (attach written statements for each witness):

Witness Name: _____ Position: _____ Phone No.: _____

Witness Name: _____ Position: _____ Phone No.: _____

Witness Name: _____ Position: _____ Phone No.: _____

Exact Location of Accident/Injury: _____

Duties Being Performed When Injured: _____

I hereby certify that the information I provided above is true and accurate, and I understand that falsifying this report may result in disciplinary action, which could include termination and possible prosecution for theft. Further, I agree to sign a Medical Release Form so that my medical history can be reviewed in accordance with HIPPA Law.

Employee's Signature: _____ Date: _____

IN THE EVENT EMPLOYEE IS UNABLE TO

The employee claiming the injury must complete this form. In the event he/she is unable, the person completing the form must sign the below statement stating he/she was authorized by the employee to complete the form on his/her behalf and indicate why the employee cannot complete.

Name and Title of Individual Completing this Form: _____

Reason(s) Injured Party Cannot Complete this Form: _____

Do Not Write Below This Line, Continue to Page 3

IRVINGTON TOWNSHIP
EMPLOYEE ACCIDENT INJURY REPORT

SUPERVISOR'S REPORT

Date Injury Reported: _____ By Whom: _____ (Name and Title)

Employee's Regular Hours: Time: _____ AM PM Injury Date: _____ Time: _____ AM PM

Nature and Extent of Injury: _____

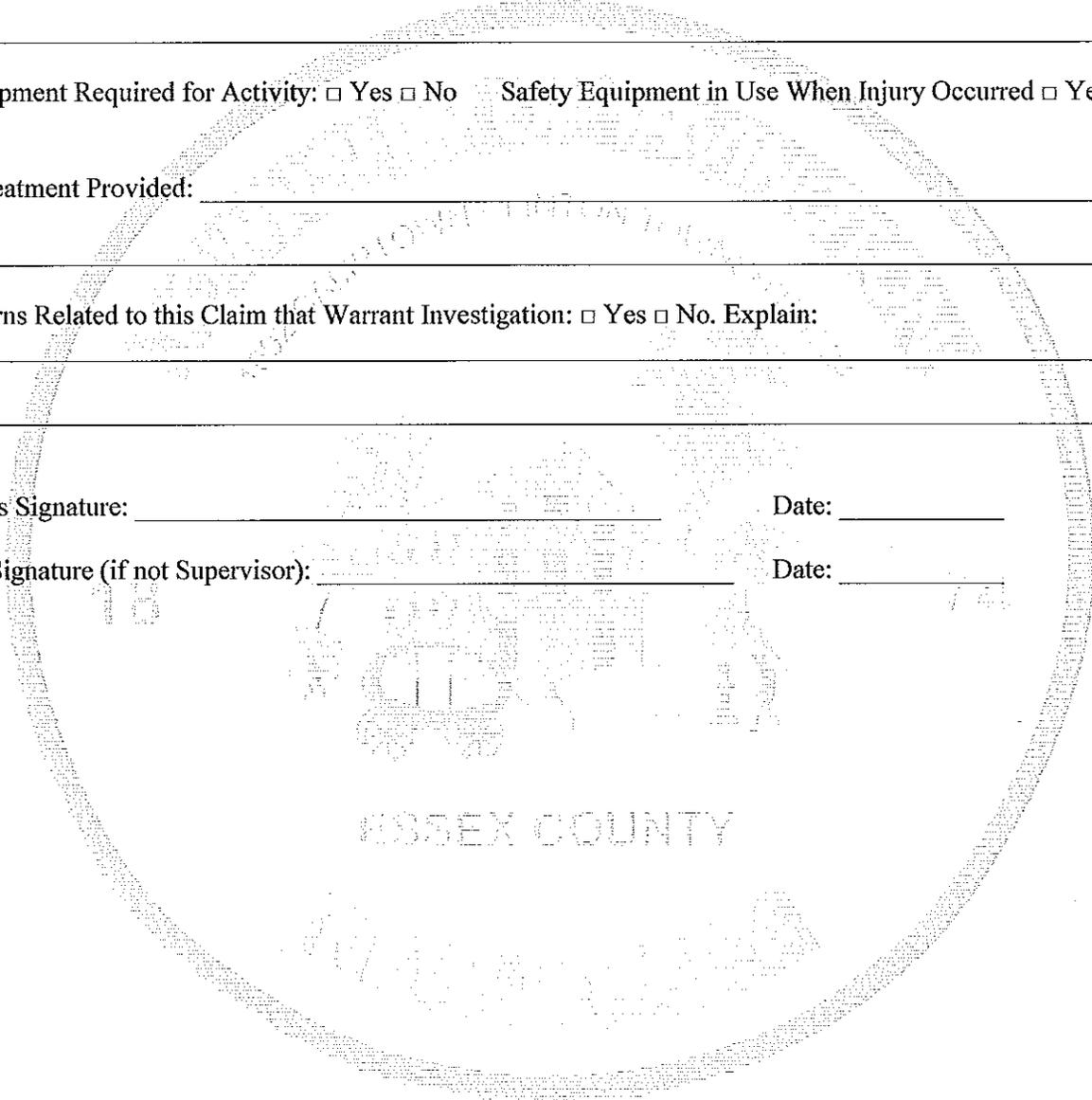
Safety Equipment Required for Activity: Yes No Safety Equipment in Use When Injury Occurred Yes No

Medical Treatment Provided: _____

Any Concerns Related to this Claim that Warrant Investigation: Yes No. Explain:

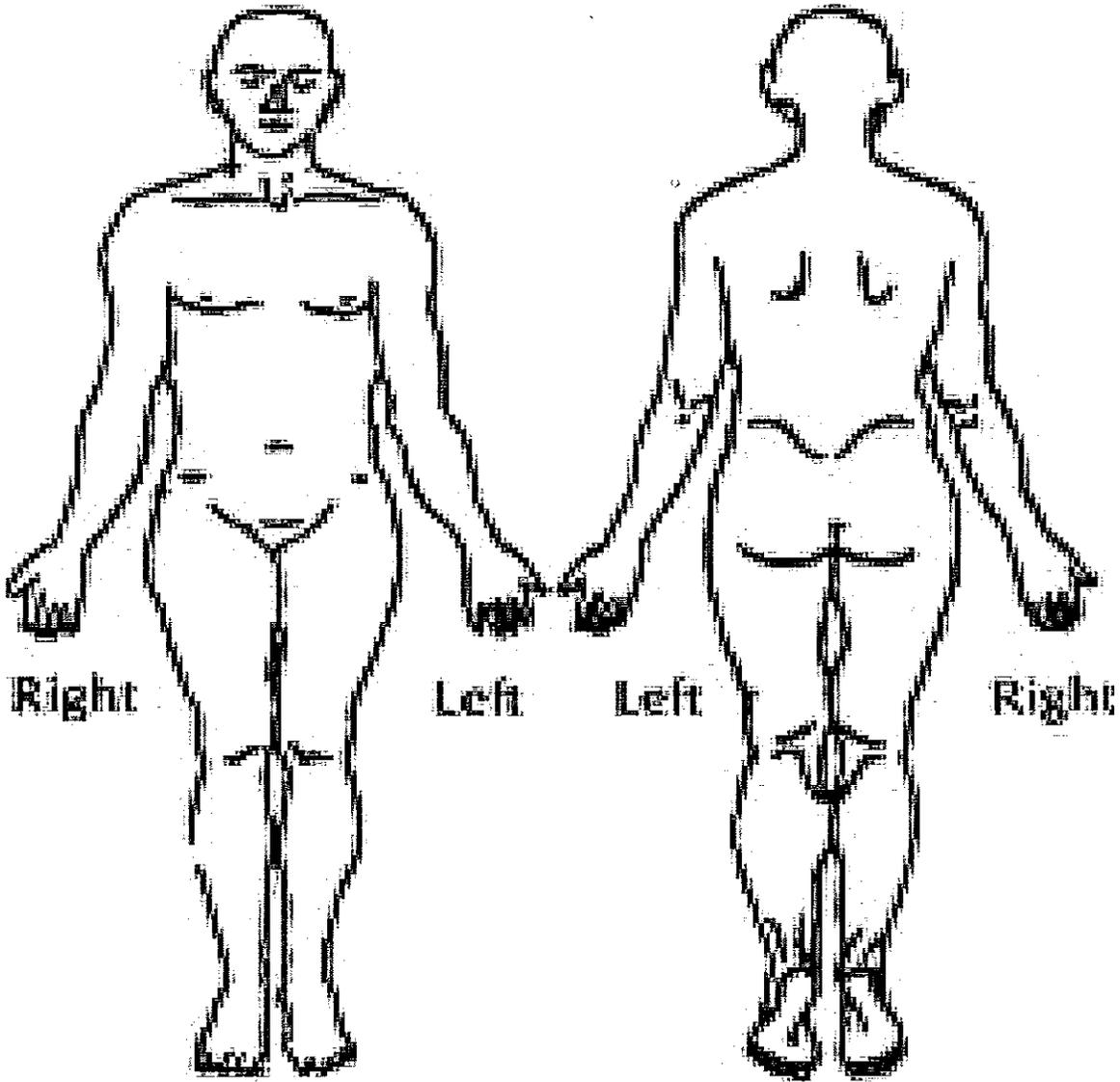
Supervisor's Signature: _____ Date: _____

Director's Signature (if not Supervisor): _____ Date: _____



IRVINGTON TOWNSHIP
EMPLOYEE ACCIDENT INJURY REPORT

Indicate what area(s) of your body was/were injured (circle the area and initial where you circled):



Employee: Signature: _____

Date: _____

If signing on employee's behalf: _____

Date: _____



TOWNSHIP OF IRVINGTON

DEPARTMENT OF ADMINISTRATION
MUNICIPAL BUILDING - CIVIC SQUARE
IRVINGTON, NJ 07111

Tony Vauss
Mayor

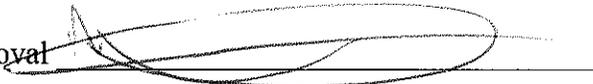
Tel. (973) 399-6621
Fax: (973) 399-6766
Email: www.irvington.net

Musa A. Malik
Business Administrator

Administrative Directive No. 9

ADA/NJLAD Reasonable Accommodation

Effective immediately, the attached form sets forth the procedure for requesting a reasonable accommodation due to a claimed disability/impairment. Musa A. Malik, Business Administrator, is hereby designated the Township 504 Accommodation Officer, and the 504 Accommodation Committee will consist of the Business Administrator and an administrator from the Department of Health and an attorney from the Legal Department.

BA Approval 

Effective 08/11/14

Cc: Tony Vauss, Mayor