

TRENTON BOARD OF EDUCATION
WORKERS' COMPENSATION FOR THE 2011 - 2012 SCHOOL YEAR

ALL TBOE EMPLOYEES WILL CONTINUE TO REPORT ALL WORK RELATED INJURIES/ILLNESSES TO
THE TBOE'S WORKERS' COMPENSATION MANAGED CARE SERVICES PROVIDER:

QUALCARE, INC.

You may call 24 hours a day, 7 days a week to Toll-free number: 1-800-425-3222

- Please be advised that effective August 1, 2011, Qualcare, Inc. will direct all TBOE staff to the below listed facility for initial evaluation and treatment of work related injuries and illnesses:

Robert Wood Johnson @ Hamilton Occupational Health
2 Hamilton Health Place
Trenton, New Jersey 08690
(609) 584-6654

- In case of an emergency, go to the nearest hospital or medical facility and then tell your employer within 24 hours
The Qualcare I.D. and Jordan Reses Prescription cards will be sent to all building sites along with the employee accident report forms
- Please discard any old employee accident report forms you may have from previous years

PLEASE NOTE: *Employee Accident Reports must be completed and forwarded to Angelia Herring, Insurance Specialist, via fax number (609) 989-4826 or inter-office delivery to the 108 North Clinton Avenue, Room 314, Trenton, New Jersey 08609 location site. If you have any questions, please call (609) 656-4900 ext. 5615 or email aherring@trenton.k12.nj.us.*

Thank you for your continued efforts in making the 2011-2012 school year a safe and healthy one!

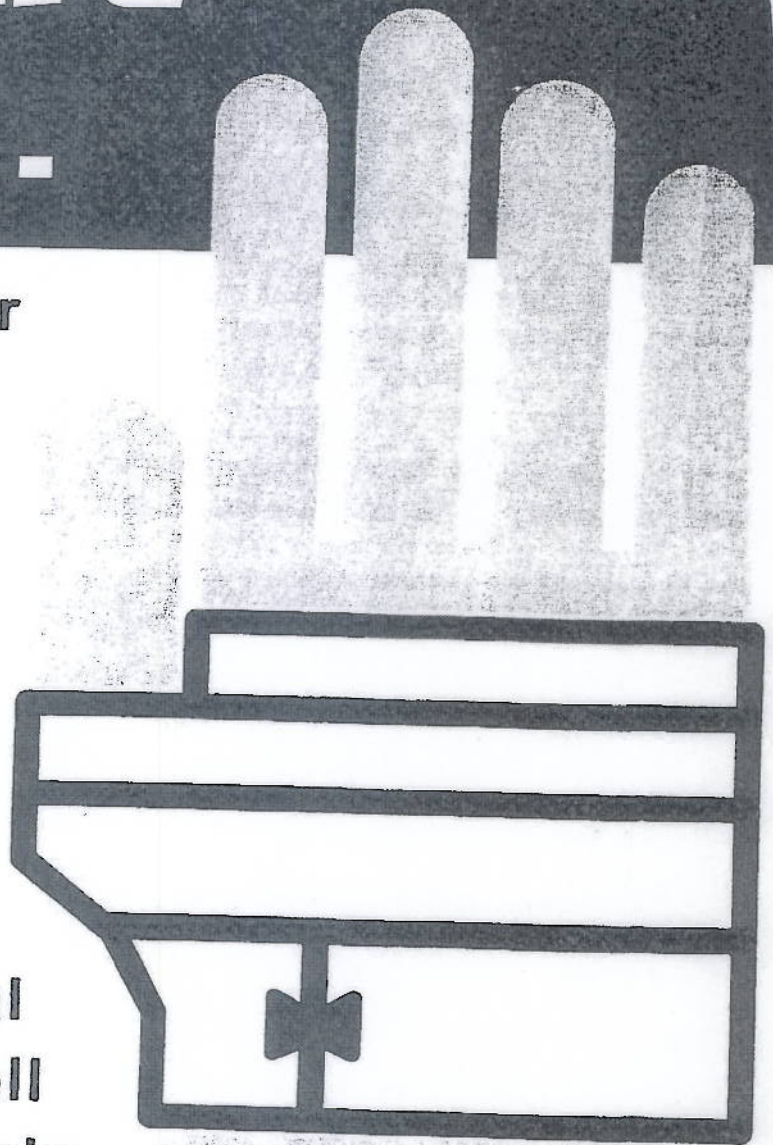


If you get **HURT** on the job...

- Tell your employer immediately or call QualCare at:

1-800-425-3222

- In case of an emergency, go to the nearest hospital or medical facility and then tell your employer within 24 hours.



1-800-425-3222

TRENTON BOARD OF EDUCATION
TRENTON, NEW JERSEY 08609
EMPLOYEE ACCIDENT REPORT

PLEASE USE THIS FORM TO REPORT ALL WORK-RELATED ILLNESSES/INJURIES INVOLVING TRENTON BOARD OF EDUCATION STAFF MEMBERS ONLY. THIS FORM SHOULD BE FAXED THE SAME DAY OF THE ILLNESS/INJURY TO: Angelia Herring, Insurance Specialist, (609) 989-4826. ANY QUESTIONS OR CONCERNS PLEASE CALL: (609) 656-4900 EXT. 5615 OR EMAIL aherring@trenton.k12.nj.us

Name of Injured Employee: _____
(Last Name, First Name, Middle Initial)

Home Address: _____

Home and Cell Telephone Numbers: _____

Social Security No.: _____ Date of Birth: _____ Age: _____ Sex: M/ F

Occupation: _____ 10/12 Month Employee: ___ Normal Working Hours: _____

TBOE School Site or Building Where Employed: _____

Name of Private Physician/HMO Physician: _____

Address of Physician: _____ Telephone No. _____

DATE AND TIME OF ACCIDENT _____

TO WHOM ACCIDENT INITIALLY REPORTED? _____

WHERE DID ACCIDENT OCCUR? (Actual site location, address, city, county)

What was employee doing when injured? (Please be specific as to what caused injury/illness. Use separate sheet if necessary.)

Object/Substance, Machine or Tool, that directly injured employee. (If student/s caused injury, please list their name/s guardian's name, address, age, date of birth, and if student is classified.)

Nature of Injury or Illness and part/s of body affected. (Formal diagnosis not required)

Did Employee Contact Qualcare, Inc. for Medical Services and Referred to RWJ @ Hamilton Occupational Health/Other Facility _____ YES _____ NO

Name/s of Witness/es to injury/illness: _____

Completed by: _____ Title: _____
(Please print)

Signature: _____ Date: _____

**TRENTON PUBLIC SCHOOLS/TRENTON, NEW JERSEY 08609
EMPLOYEE ACCIDENT REPORT**

PLEASE USE THIS FORM TO REPORT ALL WORK-RELATED ILLNESSES/INJURIES INVOLVING STAFF MEMBERS. THIS FORM SHOULD BE FAXED THE SAME DAY OF THE ILLNESS/INJURY TO: ANGELIA HERRING, INSURANCE SPECIALIST, (609) 989-4826. ANY QUESTIONS OR CONCERNS PLEASE CALL: (609) 656-4900 EXT. 5615 OR EMAIL aherring@trenton.k12.nj.us

IMMEDIATE SUPERVISOR'S INJURY/ILLNESS REPORT

TODAY'S DATE: _____ DATE OF ACCIDENT/TIME _____

NAME OF INJURED EMPLOYEE: _____

LOCATION: _____ JOB TITLE: _____

SUPERVISOR'S NAME: _____

SPECIFIC LOCATION OF ACCIDENT: _____

NATURE OF INJURY/ILLNESS: _____

LIST ANY WITNESSES: _____

SAFETY EQUIPMENT USED: (Specify) _____

SAFETY EQUIPMENT NOT USED: (Specify) _____

TRAINING ADEQUATE: YES ___ NO ___ ADDITIONAL TRAINING NEEDED: YES ___ NO ___

TO YOUR KNOWLEDGE HOW DID THIS INJURY/ILLNESS OCCUR: (Give specific details please) _____

IN YOUR OPINION WHAT STEPS CAN BE TAKEN TO AVOID A SIMILAR TYPE LOSS?

Supervisor's Signature

ADDITIONAL COMMENTS: (Please list below and/or on reverse side)

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WITNESS STATEMENT REPORT OF INJURY/ILLNESS

NAME OF INJURED EMPLOYEE: _____

YOUR NAME: _____

DATE OF INJURY: _____ TODAY'S DATE: _____

YOUR JOB TITLE: _____

SITE/LOCATION OF INJURY/ILLNESS: _____

YOUR JOB TITLE: _____

REMARKS: (In your own words, give in detail how this injury/illness occurred)

STATE WHAT YOU THINK CAUSED THIS INJURY/ILLNESS:

PLEASE LIST ANY OTHER WITNESSES:

WHAT IN YOUR OPINION CAN BE DONE TO PREVENT SIMILAR TYPE INJURY/ILLNESS?

SIGNATURE OF WITNESS: _____



Name: _____ Date: ____/____/____

SS# (Member ID): _____

Bin Number#: 600518 Group #: 30011022

Authorized Administrator: QualCare – 800.425.3222

Eligibility and Drug Coverage Inquiries: 800.848.4050

*** First Fill maximum 5 day supply ***

QUALCARE Workers' Compensation
Network

Name

Employer

IF YOU GET HURT ON THE JOB

- TELL YOUR EMPLOYER IMMEDIATELY OR CALL QUALCARE AT 1-800-425-3222
- DO NOT GO TO YOUR OWN PRIVATE DOCTOR OR CHIROPRACTOR
- IN CASE OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR MEDICAL FACILITY AND THEN TELL YOUR EMPLOYER AND QUALCARE WITHIN 24 HOURS
- PRESENT THIS CARD TO THE ADMITTING OFFICE OR DOCTOR'S OFFICE AT THE TIME OF REGISTRATION.

Provider Instructions:

- PRE-CERTIFICATION IS REQUIRED PRIOR TO TREATMENT
- Call QualCare at 1-800-425-3222 for approval
- SUBMIT ALL BILLS TO:
QualCare, Inc.
P.O. Box 309
Piscataway, NJ 08855-0309
Attn: Workers' Compensation Claims Dept.