Manasquan Fire Department
Manasquan Fire District #1
Standard Operating Guideline

110.00

Title: Work Related Injuries and Illnesses

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Purpose: To establish the procedure for the reporting of work related injuries and treatment of injured employees.

Scope: This action will cover all employees of the Manasquan Fire Department/Manasquan Fire District #1 who are injured while on the job.

General: All employees and officers shall follow the below guidelines for reporting of injuries and arranging for medical treatment of employees when necessary.

110.00.01: Reporting of Injuries

All injuries will be reported to the officer in charge immediately.

The Director of Fire Services will be notified as soon as conditions permit.

All injuries must be reported within 24 hours of occurrence.

If the injury is of a life threatening type the employee will be transported to the nearest hospital.

If the injury is non life threatening and hospital treatment is needed, the employee will utilize Jersey Shore Medical Center 732-775-5500.

In all other cases where the employee will receive medical attention they will go to:

Meridian Occupational Health
121-199 Fortunato Place, Neptune N.J. 732-776-4251

The officer or the employee will call the above number to set up the appointment.

This facility must be used for workman's compensation coverage

110.00.02 Paperwork

Immediately following the report of an injury or as soon as possible after the occurrence, the officer shall fill out an injury report form.

Employee information will be filled out, name, address, date of birth, social security number, age, and phone number.

Injury section will also be filled out

Person filling out form will sign and date form where indicated.

Form will be faxed or dropped off to the District office the same day as the injury being reported.

110.00.03 Return to Active Duty Clearance

Any employees requiring medical attention will be required to obtain medical clearance prior to returning to active firefighting duties.

QUAL-LYNX

LINKING YOU TO QUALITY CLAIM SERVICES

INITIAL FILING ☐ SUBSEQUENT FILING ☐

FIRST REPORT OF INJURY (FROI) – FOR E-MAIL SUBMISSIONS

Instructions for form completion and e-mailing:

- Save the master form with a new file name (File, Save As)
- Use TAB key to move through answer fields
- All information must be completed for each claim submitted
- When finished, save file again.
- E-mail form to: FROI@Qual-Lynx.com

EMPLOYER

1. Name of Self Insured Group:
2. Agency Name:
3. Street address:
4. Employer city:
5. State:
6. Zip:

EMPLOYEE/WAGE

1. Last name:
2. First name:
3. Middle initial:
4. Street address:
5. City:
6. County:
7. State:
8. Zip:
9. Home area code & telephone #:

10. Date of birth:
11. Social security #:
12. Date of hire:
13. Sex: ☐ male ☐ female
14. Occupation/job title:
15. Marital status:
    ☐ Unmarried ☐ Single/Divorced ☐ Married ☐ Separated ☐ Unknown
16. Employment status: (Please select the FIRST status that applies to the injured worker, make only ONE selection)
    1 ☐ Volunteer Worker
    2 ☐ Seasonal Employee
    3 ☐ Regular Full Time Employee
    4 ☐ Regular Part Time Employee
    5 ☐ Not Employed
    6 ☐ Retired
    7 ☐ On Strike
    8 ☐ Disabled
    9 ☐ Other
17. Wage rate: $ ☐ per day ☐ per week ☐ per month
18. Days worked per week:
19. Did employee receive full pay for day of injury? ☐ yes ☐ no
20. Did salary continue? ☐ yes ☐ no

OCCURRENCE/TREATMENT

1. Time employee began work: ☐ am ☐ pm
2. Date of injury or illness:
3. Time of occurrence: ☐ am ☐ pm
4. Last work date:
5. Did the employee finish work on the date of the occurrence?: ☐ yes ☐ no

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6. Date employer was notified of occurrence:
7. Date disability began:
8. Type of injury:
9. Part of body affected:
10. Did injury/illness/exposure occur on employer's premises? ☐ yes ☐ no
11. Department or location where accident or illness exposure occurred:
12. ZIP Code of injury site:
13. All equipment, materials or chemicals employee was using when accident or illness exposure occurred:
14. Specific activity the employee was engaged in when the accident or illness exposure occurred:
15. Work process the employee was engaged in when accident or illness exposure occurred:
16. How Injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill:
17. Date returned to work:
18. If fatal, give date of death:
19. Were safeguards or safety equipment provided? ☐ Yes ☐ No
20. Were they used? ☐ Yes ☐ No

MEDICAL PROVIDER

1. Name of Physician or Health Care Provider:
2. Address:
3. City:
4. State:
5. Zip:
6. Name of Hospital or off site treatment facility:
7. Address:

8. City:
9. State:
10. Zip:
11. Initial Treatment:
    - ☐ No Medical Treatment
    - ☐ Minor: Treatment by Employer
    - ☐ Minor: Clinic or Hospital
    - ☐ Emergency Care
    - ☐ Hospitalized greater than 24 hours
    - ☐ Future major medical/lost time anticipated

OTHER

1. Witness name:
2. Witness Area Code & Phone #:
3. Date Administrator (TPA) notified:
4. Date Report Prepared:
5. Preparer's Name:
6. Preparer's Title:
7. Preparer's Area Code & Phone #:

TO BE ANSWERED BY EMPLOYEE'S DIRECT SUPERVISOR

(Note this section can be completed and submitted as a supplement to your original First Report of Injury Filing. Do not hold up the initial filing of your First Report of Injury for this information. If you do choose to do a supplemental filing, please check the Supplemental filling box on the top of the form.)

1. Do you usually supervise this individual? ☐ Yes ☐ No
   If No, Explain:
   Who reported the accident?:
2. Was accident immediately reported? ☐ Yes ☐ No

If No, Explain:

3. Was employee working ☐ Alone ☐ With crew
4. Did you physically inspect the area where the injury occurred? ☐ Yes ☐ No
   If No, Explain:
5. Any unsafe conditions or unusual hazards present? ☐ Yes ☐ No
   If Yes, Explain:
6. Was employee wearing back support? ☐ Yes ☐ No
   If No, Explain:
7. Evidence of horseplay ☐ Yes ☐ No
   If Yes, Explain:
8. Evidence of intoxication ☐ Yes ☐ No
   If Yes, Explain:
9. Evidence of drug abuse ☐ Yes ☐ No
   If Yes, Explain:
10. Are you satisfied that the accident/injury occurred as described above? ☐ Yes ☐ No
    If No, Explain:
11. What additional training may have prevented this accident?
12. What additional training would you like Fund's Safety Director to provide?
13. What circumstances contributed to this accident?
14. What actions contributed to this accident?
15. What changes in circumstances or actions could have prevented this accident?
16. Your actions taken to minimize the chance of a recurrence?
17. Your future plans to minimize the chance of a recurrence?

Supervisor's Name:

Date: