WHAT TO DO IF YOU'RE INJURED AT WORK

1 INFORM YOUR SUPERVISOR

Notify your direct supervisor or department head immediately. They will provide you with the paperwork needed to take with you to the medical facility so insurance is billed correctly.

2 SEEK MEDICAL ATTENTION

For minor injuries, visit:
Oceanside Family Medicine & Convenient Care.
Address: 5145 Sellers St, Shallotte NC 28470
Phone: 910.754.4441

3 SUBMIT YOUR INJURY REPORT

Completed packet must be submitted to Human Resources within 48 hours of the date of injury.

Injury Reports can be found at www.townofshallotte.org, click on Human Resources, Town Employee Resources, and select Incident/Injury Report

TOWN OF SHALLOTTE North Carolina

For more information, contact HR
910.754.4032 Ext 1012

EMPLOYEE INCIDENT/INJURY REPORT

****THIS FORM IS TO BE COMPLETED WITHIN 24 HOURS OF INCIDENT****

Date of Report: ______/_______/________

Date of Incident: ______/_______/________ Time of Incident: _______________ (A.M/P.M.)

Employee Full Name: ____

Date of Birth: ______/_______/_________ Social Security #: _________________________

Mailing Address: ____

Phone Number: ____________________ Email: _____________________________________

Gender: ☐ Male ☐ Female Marital Status: __________________________________

Department: __________________________Supervisor: ______________________________

Supervisor Phone: ____________________Supervisor Email: __________________________

Position/Job Title: _______________________________ Date of Hire: _____/______/______

Number of Days worked per Week: _________ Number of Hours worked per Day: ________

Time Employee began work on Injury Date: ______________ Date Last Worked: __________

Injured Body Part (L or R): ____

Nature of Injury: ____

Cause of Injury: ____

Location of Incident: ____

Address of Incident Location: ____

Where were you directed for medical treatment: ______________________________________

Address of medical treatment facility: ____

Employee Signature: __________________________________ Date: ____________________

Supervisor Signature: __________________________________Date: ____________________

COMPLETING THIS FORM DOES NOT HOLD TOWN OF SHALLOTTE RESPONSIBLE FOR COMPENSATION IN ANY WAY.

HR TO COMPLETE THIS SECTION

Avg hourly wage: _______________ Avg daily wage: _______________

MEDICAL AUTHORIZATION & ATTENDING PHYSICIAN REPORT

EMPLOYER, complete this section

Name of Employee/Patient:	Last:	First:
Date of Injury:	Social Security Number:	
Name of Employer:		
Employer Signature:	Doctor to be Seen:	

Employer: Prior to using this form for an injured employee, briefly identify activity that would meet possible work restrictions. Work with your Claims Representative or Loss Control Specialist.

Sedentary	Light	Medium	Heavy

AUTHORIZED PHYSICIAN, complete this section

____________________________ has been treated today for ____________________________

A post accident drug test ☐ has ☐ has not been completed.

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately, no restrictions
- ☐ May resume work immediately with the following restrictions:
  - ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
  - ☐ Light work (lifting less than 20 lbs.)
  - ☐ Medium work (lifting less than 50 lbs.)
  - ☐ Heavy work (lifting less than 100 lbs)
- ☐ He/she is released to work:
  - ☐ ____________________ hours per day
  - ☐ His/her normal shift
- ☐ Repetitive Motion Restrictions:

Frequency	Left ______________	Right____________
Occasional <33% of time	_____	_____
Frequent 34-66% of time	_____	_____
Constant 67-100% of time	_____	_____

- ☐ He/she may return to work full duty on (date) ______________________________
- ☐ He/she has a return appointment on (date) ____________________ at (time) ____________________

Please indicate any referrals that are required: ______________________________

Physician Signature:	Physician Name (print or type:	Date

Contact NCLM Workers' Compensation Department for referrals, authorizations, pre-certifications or billing questions:
NCLM 308 West Jones Street Raleigh NC 27603- (888) 561-1083- (919) 715-8465 fax - claimsadmin@nclm.org

PHARMACIST:

Please process all Workers' Compensation Claims for this patient through Cypress Care Inc.
The Member Number is the SSN. The Group Number is IC1006. The Cypress Care BIN# is 010876.
If you have any questions or problems please contact Cypress Care at 1-800-419-7191.

DO NOT CHARGE THIS PATIENT FOR THE PRESCRIPTION.