FLORIDA TECH

EMPLOYEE ACCIDENT/INJURY REPORT

Please contact the Office of Compliance and Risk Management at 321-674-7563 IMMEDIATELY regarding an employee's injury.

EMPLOYEE INFORMATION

Last name _____ First name _____ Middle name _____

Full SSN _____ DOB _____ Gender: ❑ Male ❑ Female Marital status _____

Home address _____ Street/Apt. # _____

City _____ State _____ ZIP _____

Cell # _____ Work # _____ Email _____

❑ Full time ❑ Part time Salary/hourly wage _____ Date of hire _____

ACCIDENT INFORMATION

Date of accident_____ Time of accident _____ ❑ AM ❑ PM Date first reported_____

Occurred on campus: ❑ Yes ❑ No If on campus, exact location _____

Type of location (lab shop, office, warehouse, etc.) _____

Employee description of accident (include cause of injury):

Injury/illness that occurred_____ Part of body affected _____

Cause of injury _____

Paid for date of injury: ❑ Yes ❑ No Last date employee worked _____

Return to work? ❑ Yes ❑ No If yes, give date _____ Date of death (if applicable) _____

MEDICAL INFORMATION

Employee refused medical care at time of injury: ❑ Yes ❑ No Treated by a physician? ❑ Yes ❑ No

Physician/hospital name _____ Phone _____

Address_____City _____ State_____ZIP _____

List of activity prior to accident (work-related activity only):

Has this part of your body been injured before? ❑ Yes ❑ No If yes, when_____

Employee signature_____ Date_____

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SUPERVISOR ACCIDENT/INJURY REPORT

(To be completed by supervisor)

Did activity involve operating a vehicle? ❑ Yes ❑ No Was individual licensed to operate vehicle/equipment? ❑ Yes ❑ No

Did individual take the appropriate safety training? ❑ Yes ❑ No If yes, what was the course(s)? _____

Personal protective equipment required and available? ❑ Yes ❑ No

Personal protective equipment used? ❑ Yes ❑ No

If yes, what type of equipment? _____

If no, what PPE should have been used to prevent/minimize the accident/injury? _____

Were stated or written procedures followed that caused or contributed to the accident? ❑ Yes ❑ No

Was there a discrepancy? ❑ Yes ❑ No

How was it performed improperly? _____

Type of property/material involved in accident _____

Owner of property _____

Estimated cost of damage _____

Supervisor name _____ Phone # _____

Supervisor signature _____ Date _____

TO BE COMPLETED BY THE OFFICE OF COMPLIANCE AND RISK MANAGEMENT

Name of company:

Florida Institute of Technology
150 W. University Blvd.
Melbourne, FL 32901

Insurer information:

Cannon Cochran Management Services Inc.
P.O. Box 948399, Maitland, FL 32749-8399
866-291-0194 / 407-660-5600 / Fax: 217-477-6946
FICURMAmail@ccmsi.com

Federal ID number 59-6046500 Policy/member number 00002170120000030129462019

Nature of business Education

Restricted duty? ❑ Yes ❑ No Did supervisor accommodate restriction? ❑ Yes ❑ No

If yes, from *(start date)* _____ to*(end date)* _____

MMI date _____

FALSE AND FRAUDULENT CLAIM WARNING

Please read the following information carefully. This form must be signed and returned within 30 days of the date it was received, stating that you have reviewed, understand and acknowledge the statement of benefits and/or payments shall be suspended until such signature obtained.

Workers' Compensation fraud includes but is not limited to the following:

- Requesting and/or receiving temporary total, temporary partial, permanent total disability or impairment benefits while working for gain as an employee of a business, independent contractor, yourself or a business and not reporting that income to the insurance company.
- Making a false or written statement and/or submitting false documents to your employer, your physician and/or the insurance company or their representatives for the purpose of filing or supporting a claim for workers' compensation benefits.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician and/or the insurance company or their representatives.
- Failing to report earnings when requested to do so by the insurance company.
- Selling your personal information to third parties for use of misrepresenting facts to any medical provider or insurance company.

Florida

Any person who knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud punishable as provided in Florida Statute 817.234.

I have reviewed, understand and acknowledge the above. This information is true and correct to the best of my knowledge.

Worker's Name: _____

Please type or print

Claim #: _____ Employee: _____

Employer: _____

Employee's Address: _____

Phone: _____

Worker's Signature:_____ Date: _____

Please type or print

Cannon Cochran Management Services, Inc.
PO Box 948399 I Maitland, FL 32794-8399
866-291-0194 | 407-660-5600 | Fax: 217-477-6946 | FICURMAmail@ccmsi.com

AUTHORIZATION FOR MEDICAL RECORDS AND COMMUNICATION RELEASE

Name: _____ Date of Birth: _____ Social Security #:_____

I hereby authorize any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of my mental or physical health, history, condition or wellbeing, to supply such information to my employer or its insurance carrier, claims administrator or attorneys.

I specifically authorize any treating physician or medical care provider to communicate orally or in writing with my employer or its insurance company, claims administrator, rehabilitation or medical management consultant or attorneys as to my care and treatment, and as to any other issues including diagnosis, prognosis, causal connection of care and treatment to my work injury or duties, and ability to work. I hereby waive my physician-patient privilege. In conjunction with this, I also authorize any treating physician or medical provider to review any additional materials provided to them.

A photocopy of this authorization shall be as valid as the original. This release shall remain valid for the length of my claim.

Note: Workers' Compensation Requests Are Exempt From HIPAA. Pursuant to 45 CFR, Sect. 164.512(1) a covered entity may without penalty under HIPAA disclose protected health information to the extent necessary to comply with the law relating to workers' compensation.

Name *(please print)*: _____

Signature: _____ Date: _____

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REQUEST FOR MILEAGE REIMBURSEMENT

Please fax or email the completed form to the adjuster for handling. Thank you.

Name:			
Employer:	Florida Institute of Technology		
Claim Number:			
Claimant Address:			
Work Address:			
Date Of Injury:		Adjusters:	Terri Krepps/Pamela Schlegel

Date of Visit	Name of Medical Facility (including pharmacies) with address	Roundtrip Miles	Residence or Work (Please indicate)

Total Miles: 0.00 x 0.44.5 = $ _____

I hereby certify or affirm that the above mileage was incurred by me as necessary traveling expenses related to those medical facility visits pursuant to my workers' compensation case.

Signature: _____ Date: _____

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FICURMA
WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name	
Group#:	P2KA
PCN:	Workers' Compensation
ID# (Claim Number):	
Date of Accident:	
Processor:	myMatrixx
Bin#:	003858
Day supply is limited to 14 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

FICURMA has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY, PLEASE CALL (877) 804-4900.

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

FLORIDA TECH

WORKERS' COMPENSATION WITNESS REPORT

(To be completed by witness only)

Name of injured employee _____

Name of witness _____

Telephone # of witness _____

Location where incident occurred _____

Date of incident _____ Time of incident _____

1. What were you (the witness) doing at the time of the incident?

   _____

2. How and when did you become aware ef the incident?

   _____

3. What did you hear at the time of the incident?

   _____

4. Describe what you saw at the time of the incident?

   _____

5. Who else was present?

   _____

6. Please relate any additional information you have pertaining to the incident:

Witness signature _____ Date _____