FLORIDA TECH EMPLOYEE ACCIDENT/ INJURY REPORT

Contact Office of Compliance and Risk Management @ 674-8885 IMMEDIATELY regarding an Employee's Injury. Employee AND Supervisor must complete this report.

EMPLOYEE INFORMATION Please Print clearly:

NAME: SOCIAL SECURITY#:

EMPLOYEE ID#: DATE OF BIRTH:

DATE OF INCIDENT: TIME OF INCIDENT:

DATE OF HIRE: JOB TITLE:

H0ME ADDRESS: (If PO Box list physical address as well.)

HOME PHONE NUMBER: CELL PHONE#:

WORK PHONE NUMBER: SUPERVISOR:

MARITAL STATUS: # OF DEPENDENTS:

FULL TIME OR PART TIME SALARY/HRLYWAGE:

ACCIDENT INFORMATION

PART OF BODY INJURED:

WHAT WERE YOU DOING WHEN INJURED:(COMPLETE DESCRIPTION)

NAME OF TOOLS,EQUIPMENT OR HAZARDOUS MATERIAL IN USE AT THE TIME:

LOCATION OF INCIDENT:

LIST WITNESSES:

WHAT TIME DID YOU START YOUR WORK DAY?

Do you feel your injury/illness is directly related to work? YES ( ) NO ( )

EMPLOYEE SIGNATURE: DATE:

Any person who, knowingly and with intent to injure, defraud, or deceive any employer, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided ins. 817.234. Section 440.105(7), F.S.

MEDICAL CARE PROVIDERS ARE ASSIGNED TO YOU IF YOU ARE INJURED ON THE JOB. IT IS YOUR RESPONSIBILITY TO NOTIFY US IF YOU WANT MEDICAL ATTN

TO BE COMPLETED BY SUPERVISOR:

Do you agree with the description of the incident?

What corrective actions will take place to prevent future incidents?

SUPERVISORS SIGNATURE: DATE:

LIST ALL WITNESSES * ATTACH STATEMENTS

*Root Cause Analysis or Motor Vehicle Accident Investigation may be required as follow up.

WORKER'S COMPENSATION

TREATMENT AUTHORIZATION FORM

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Account Number: F45

Employer Name: _____

Employer Address: _____

Employee Name: _____

Social Security Number: ***-**- _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Person Issuing Form: _____

Supervisors: Please give this completed form to the injured employee to take with them to the physician. You must file the First Report of Injury with CCMSI within 24 hours of the injury.

This form is for one time use, only on this date.

Providers: You must call CCMSI at (407) 660-5600 or email FICURMAmail@ccmsi.com prior to any additional treatment/admission or referral, other than an emergency situation. In an emergency situation, notification to CCMSI is required within 24 hours,

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.

Workers Name:

Please type or print

Claim #:_____ Employee: _____

Employer: _____

Employees' Address: _____

Phone: _ _____

Workers' Signature: _____Date: _____

Cannon Cochran Management Services, Inc.
2600 Lake Lucien Drive ● Suite 225 ● Maitland, FL 32751
866-291-0194 ● 407-660-5600 ● Fax: 217-477-6946 ● www.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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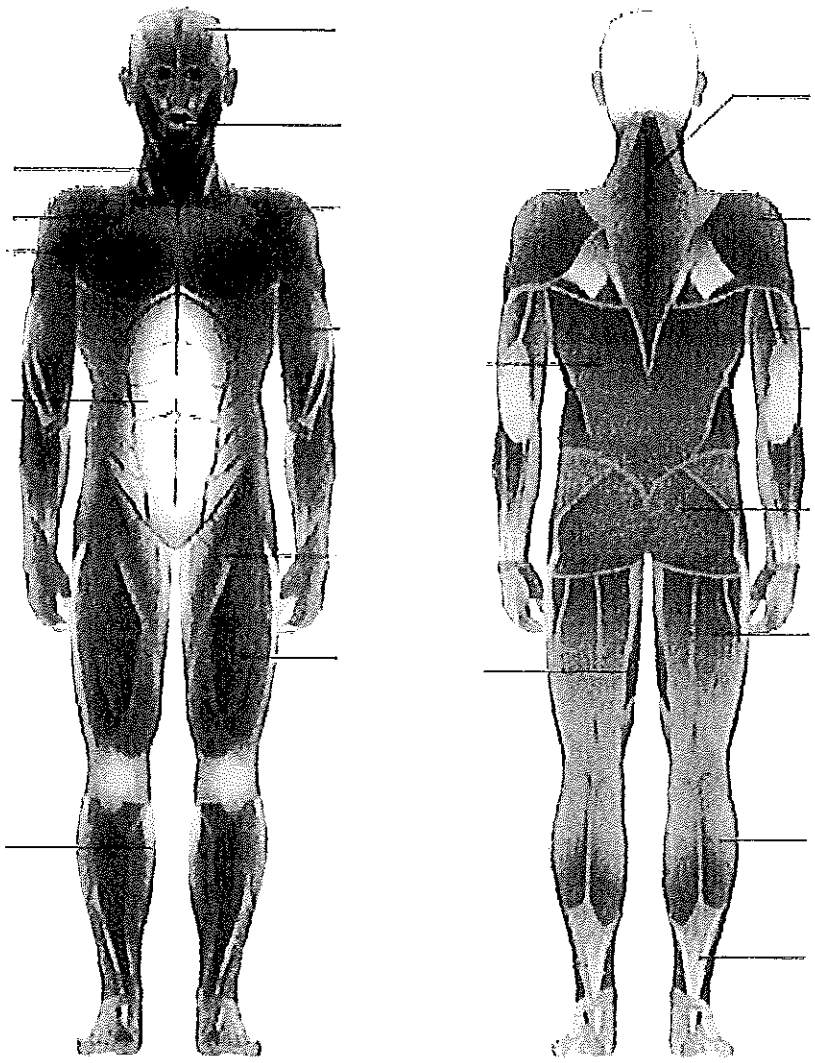
Indicate on Diagram Location of Injury



Injury:

1 ☐ No apparent injury
2 ☐ Contusions
3 ☐ Lacerations
4 ☐ Possible fracture
5 ☐ Fracture
6 ☐ Head involved
7 ☐ Burn
8 ☐ Hematoma
9 ☐ Abrasion
Other
10 ☐ _____

Prior Injuries
Prior W.C. Injuries

A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

I hereby declare that the facts stated are true.
Signature_____**Date**_____

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#:	10602857
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
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 Institute of Technology

WITNESS STATEMENT OF FACTS

Witness Information

Name:_____
Last Name First Name Middle Initial

FIT Affiliation: ☐Staff ☐Faculty ☐Student ☐Non-FIT

Home address:_____City_____State_____Zip_____

Incident Statement:

You have been identified as a witness to an accident/incident _____
(Employees Name)
that was reported to have occurred on _____. Please respond to the following
(Date of Accident/Incident)
question as accurately as possible.

Did you actually witness the accident/incident referenced above? ☐ Yes ☐ No

If "*Yes*", provide a detailed summary of your observation of the accident/incident (use additional pages if needed): _____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby certify that the above statement is true and correct. Furthermore, I have made this statement of my own free will without any prompting, urging, or influence from any other person.

_____ _____ _____
Print Name *Signature* *Date*

I am injured. Now what?

FAQ's regarding Workers' Compensation

How long do I have to report a claim to my employer?

You should report it as soon as possible, but no later than thirty (30) days or your claim may be denied.

What doctor can I go to?

Your employer or insurance company, upon becoming aware of your injury will direct you to a health care provider for such period as the nature of the injury or the process of recovery may require. Medical care must be authorized by the employer and/or insurance company.

Why can't I go to the doctor of my choice?

Per Florida Statute 440.13(2)(a), the law requires that the employer/insurance company provide the appropriate medical care.

Can I go to my own personal physician?

No. You must go to an authorized physician provided by your employer, CCMSI or FICURMA.

The doctor is not helping me. Can I request a different doctor for my treatment?

Yes. Per Florida Statute 440.13(2) (f), you are entitled to a one time change per accident. The request for a change in physician must be in writing and provided to the insurance company. Upon receipt of the request, the insurance company will select and authorize an alternative physician within five days of receipt of the written request. The injured worker or insurance company may also select a one-time Independent Medical Examination (IME), per accident. Please note, if your accident occurred on or after 10/1/03, the party requesting the IME is responsible for payment.

Will I have to pay any medical bills?

No, all authorized medical bills should be submitted by the medical provider to CCMSI for payment until you reach maximum medical improvement. Once you reach Maximum Medical Improvement you will be required to pay a $10.00 co-pay per visit.

If prescribed, how do I get my prescription filled?

If a prescription is prescribed by your authorized physician, please take the prescription to your pharmacist along with the information from **myMatrixx** to ensure your prescriptions are billed directly to the insurance company. In rare cases you may be asked to pay for your medications: if this happens, you will be reimbursed any money you have to advance once receipts are provided to the insurance company.

What is my responsibility when the doctor places me on restricted duty?

It is your responsibility to communicate with your employer following your appointments. If you are given restrictions and/or placed out of work any time during your treatment, please ensure they are communicated to your employer immediately. Please remember, the doctor gives you restrictions until your next visit to help you recover from your injury. It is extremely important that you observe your restrictions at work as well as in your daily life.

Do I have to attend my appointments?

Yes. Time, effort and expense are put into providing your medical care. If you do not follow the doctor's direction and attend all medical appointments your case may be terminated for non-compliance and all benefits suspended.

If a medical bill comes to my house, what do I do?

Fax, mail or bring the medical bill to the office and if it is related to the claim, CCMSI will pay all authorized invoices for your claim.

Will I get paid mileage to my medical appointments?

If you, a family member or friend drives you to an authorized appointment, physical therapy, hospital, diagnostic testing or pharmacy you are entitled to mileage reimbursement @ .44.5 cents per mile. A form is available to document the appropriate mileage.

When do I get my first check?

You should receive the first check within three (3) weeks after reporting your injury to FICURMA/CCMSI and have been off work by an authorized treating physician.

How much will I be paid?

In most cases, benefits are calculated at 66-2/3 percent of your average weekly wage up to the state max for the year of your accident. If you were injured on or after October 1, 2003, your average weekly wage is calculated using wages earned 13 weeks prior to your injury, not counting the week in which you were injured

Will I be paid if the doctor takes me off work?

In most cases, your first check will be from the 8th day of disability through the time your authorized treating physician releases you to return to work. Under Florida law, you are not paid for the first seven days of disability, unless you are out more than 21 days.

Will the check come to my house?

If you are entitled to benefits, your check will be mailed to your home. Please make sure we have the most up to date information regarding your address and phone number.

Can I receive unemployment compensation and workers' compensation benefits at the same time?

No, not if you are receiving temporary total or permanent disability benefits, you must be medically able and available to work to qualify for unemployment benefits.

Will I get fired because of my injury?

No. It is against the law to fire you because you have filed or attempted to file a workers' compensation claim.

Who do I contact if I have any questions concerning my benefits?

CCMSI at (407) 660-5600. Their mailing address is 2600 Lake Lucien Drive, Suite 225, Maitland, FL 32751

RETURN TO WORK PROGRAM

- We strive to maintain a safe work environment for our employees. However, it is the responsibility of each employee to cooperate in promoting safety. Stay alert at all times. Follow safety regulations at all times. If a safety regulation is not understood, discuss it with your supervisor immediately. If a condition that could present a safety hazard is observed, report it immediately. (24-48 hours) In person is preferred. If this is not an option please phone 674-8885.

- We provide our employees with personal protective equipment. Failure to wear a safety device, including a seat belt, is a violation of our safety policy. If injured on the job because of failure to wear an issued safety device, your worker's compensation benefits may be reduced or denied.

- Any injury or accident must be reported (verbal or written) to your supervisor. If an accident occurs while working, you must stop work and report it immediately. All accidents are reported to the Office of Compliance and Risk Management.

- If you sustain a work-related injury and you are unable to return to work to perform your regular job, we will make every effort to bring you back to work in a temporary modified-duty position however modified-work may not always be available.

- The Office of Compliance and Risk Management will complete an accident report, forward it to our insurance carrier and give you a copy of the accident report for your records. The adjuster will contact you to explain workers compensation benefits.

- Please provide the Office of Compliance and Risk Management with a medical status report after each appointment with the assigned workers' compensation physician. This will allow the company to determine what position is available within your restrictions. Our goal is to provide an opportunity for continued employment that is within your restrictions until you are able to return to your regular position.

- Employees who are released to light duty must contact the Office of Compliance and Risk Management immediately. We will review any restrictions given and implement the process of our Return to Work Program.

- We will strive to make modified duty work always available. If you fail to accept a modified-duty assignment or if you fail to return to work after you have been cleared by your treating physician, you may jeopardize your worker's compensation benefits. Employees working in modified-duty work assignments will be held to the same performance standards and expectations as other employees. Employee Handbook/Faculty Handbook apply. This program does not create an entitlement or right to a modified duty assignment. This policy does not alter an employee's at will employment status.

- Make sure you go to all your scheduled appointments. Appointments should be scheduled at the end of the work day if possible. If your appointment is scheduled in the morning you must return to work after the appointment.

- All treating medical providers shall be advised that Florida Tech has a modified duty program and we will need the appropriate restrictions listed to minimize further injury and promote the healing process.

- While you are on light duty our normal policies are still in place. If you are unable to report to work, you must contact your supervisor immediately.

- Failure to call in or show up for light or modified duty assignment may jeopardize your eligibility for worker's compensation indemnity benefits.

- In addition, you must provide your supervisor and the Office of Compliance and Risk Management with a doctor's note for all absences related to your injury within 24 hours.

- Follow the doctor's recommendations in regards to your restrictions, therapies and medications, not only in the workplace but at home.