SOMERSET COUNTY JOINT INSURANCE FUND

Procedure for Reporting Work –Related Injuries

When an employee gets injured on the job:

1. Injured employee reports injury to supervisor and then immediately notifies Qual-Lynx by calling 1-800-425-3222 to speak with a Qual-Lynx Intake Coordinator. This pertains to all shifts.
   - In case of an emergency, the employee should go to the nearest hospital and then notify Qual-Lynx as soon as medically possible.
   - Qual-Lynx is available 24/7. If after hours (after 6pm and weekends) follow prompts to speak with "On Call Nurse", leave a message, and expect a return call within 10-15 minutes.
2. The Qual-Lynx Intake Unit captures the first accident report information and communicates it to the Qual-Lynx Claims Department. If a compensability decision is required, the Nurse Case Manager will contact Qual-Lynx Claims Department for a decision.
3. The Nurse Case Manager will direct the employee to an appropriate provider and the Intake Unit will make the necessary appointments.
4. The employer should immediately complete the FROI (First Report of Injury) and forward it to Qual-Lynx. The injured employee must complete the Employee Accident Form and submit to supervisor, or to Qual-Lynx.
5. The injured employee will provide the employer with written documentation from the treating doctors regarding medical status and availability for work.
6. Nurse Case Manager will supply medical status and availability for work information to Qual-Lynx Claims Department and the employer contact person.
7. The nurse case manager will call the employer's designated contact person to discuss alternate duty positions when appropriate.
8. Should the employer or the employee receive any medical bills associated with a work-related injury Qual-Lynx is managing, please forward them to Qual-Lynx. They will review the bills for repricing and issuance of checks.

SOMERSET COUNTY JOINT INSURANCE FUND
NOTIFICATION PROCEDURES FOR REPORTING WORKERS COMPENSATION

INJURED EMPLOYEE	SUPERVISOR	EMERGENCY PROCEDURES	FATALITIES, HOSPITALIZATIONS, AMPUTATIONS, & LOSS OF AN EYE
1. Notify Supervisor.	1. Make sure employee calls QUAL-LYNX and follows their directions. If the employee cannot call, the supervisor must assume this responsibility.	1. Injured employee seeks medical care at nearest emergency room.	**1. Work related in-patient hospitalizations, amputations or loss of an eye, call the NJ DEPARTMENT OF LABOR @ 1-800-624-1644 within 24 hours and notify HUMAN RESOURCES.**
2. Call **QUAL-LYNX 1-800-425-3222.** Speak with Intake Nurse and report incident. Follow instructions given by intake nurse. Exception: If a true emergency, employees should go directly to Somerset Medical Center, Hunterdon Medical Center or closest Emergency Room. **QUAL-LYNX Hours: 1-800-425-3222** You may call this number 24/7. If the office is closed (after 6pm and weekends) follow prompts to speak with "On Call Nurse", leave a message, and you'll receive a call within 10-15 minutes. **US HealthWorks** Bridgewater M-F 8-8 S/S 9-3 908.231.0777 Somerset M-F 8-4:30 732.748.1900 **Concentra** S. Plainfield M-F 8-5 908.757.1424 Parsippany M-F 8-8 Sa 8-5/Su 9-2 973.882.3217	2. Fill out Supervisor's report and forward to Human Resources Department along with appropriate job description for the injured employee.	2. A Rescue Squad must be called if an employee suffers acute conditions. By way of example but not limited to: • Chest pain • Difficulty breathing • Closed head injury and/or any head injury that includes dizziness, nausea or vomiting, loss of consciousness and/or blurred vision • Allergic reactions which involve any unusual swelling or rash, tingling in extremities, dizziness or shortness of breath • Profuse, uncontrolled bleeding **DO NOT ATTEMPT TO TRANSPORT EMPLOYEES WITH THESE SYMPTOMS.**	**2. If an employee dies as a result of a work related injury call the NJ DEPARTMENT OF LABOR @ 1-800-624-1644 within 8 hours and notify HUMAN RESOURCES.**
3. Fill out employee report and forward to Human Resources.	3. Call Human Resources to report accident.	3. Supervisor notifies QUAL-LYNX of the Emergency.	**3. FAILURE TO NOTIFY THE NJ DEPARTMENT OF LABOR WITHIN THE REQUIRED TIME WILL RESULT IN A FINE AND PENALTY FOR THE ENTITY.**
4. Employee must call **QUAL-LYNX** on the next business day to advise they have been seen at US HealthWorks, Concentra, etc., or Somerset Medical Center, or Hunterdon Medical Center.		4. Employee reports back to supervisor and follows procedures as indicated in previous columns.	

ALL NECESSARY PAPERWORK REGARDING WORK RELATED INJURIES MUST BE COMPLETED AND SUBMITTED TO HUMAN RESOURCES WITHIN 48 HOURS OF AN ACCIDENT, WITH EXCEPTION OF A WORK RELATED FATALITY WHICH MUST BE REPORTED WITHIN 8 HOURS. ANY WORK RELATED IN-HOSPITAL ADMISSIONS, AMPUTATIONS, OR LOSSES OF THE EYE, MUST BE REPORTED WITHIN 24 HOURS.

EMPLOYEE ACCIDENT FORM

Return to:
Qual-Lynx
30 Knightsbridge Rd.
Piscataway NJ 08854

EMPLOYEE NAME	I.D.	Time of Injury	Date of Injury	File Number

Please List Your Primary Care Physician and his/her address for the past ten years

Briefly describe how you got hurt and when the injury or illness occurred.

What part(s) of the body were hurt; and in what part(s) of the body do you currently feel pain?

Have you had treatment in the past for the same or similar medical condition? Yes ____ No _____
If yes, please provide the name and address of the treating physician(s) for this condition. List any medications you are or were taking for this condition/injury?

Have you been treated in the past by a chiropractor? Yes____ No _____
If yes, please provide the name and address of the chiropractor(s):

Have you filed any workers' compensation claims(s) in the past for this medical condition? Yes ____ No ____
If yes, please provide the details of the previous claim(s):

Have you been injured in the past in any motor vehicle collisions? Yes____ No____
If yes, please provide the details of the crash, date, and the nature of the injury and treatment:

Do you have any outside employment? Yes____ No____
If yes, please list the names and addresses of these employers:

Do you currently (in the past 12 months) participate in any athletic, recreational or sporting activities? Yes____ No____
If yes, please list the activities you participate in:

To whom did you first report the injury to and when?

Were there any witnesses to your injury? If so, who?

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital or other person or institution to permit Qual-Lynx or its representative to examine, make, or be furnished with any information concerning illness or injury sustained by me including treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photo static or scanned copy of this authorization shall be considered as valid as the original.

EMPLOYEE SIGNATURE	SOCIAL SECURITY #	DATE

QUAL-LYNX
LINKING YOU TO QUALITY CLAIM SERVICES

PO Box 1209, Piscataway, NJ 08855
Phone: 908-222-7500 Fax: 732-465-7355

FIRST REPORT OF INJURY (FROI) / INCIDENT INVESTIGATION FORM

FAX: 732-465-7355 or EMAIL (scan into PDF format): froi@qual-lynx.com

INITIAL FILING _____ SUBSEQUENT FILING _____

EMPLOYER

1. Name of Joint Insurance Fund: **Somerset County Joint Insurance Fund**
2. Name of Fund Member: _____
3. Street address: _____
4. Employer city: _____
5. State: _____ Zip: _____

EMPLOYEE/WAGE

1. FULL NAME: _____
2. FULL ADDRESS: _____
   _____
3. HOME AREA CODE AND TELEPHONE #: _____
4. Date of Birth: _____ 5. Social Security #: _____
6. Date of Hire: _____ 7. Sex: Male ____ Female ____
8. Occupation/Job Title: _____
9. Marital Status: Unmarried ____ Single/Divorced ____ Married ____ Separated ____ Unknown ____
10. Employment Status: (Please select the FIRST status that applies to the injured worker, make only ONE choice)
    Volunteer ____ Seasonal Employee ____ Regular Full Time ____ Regular Part Time ____
    Not Employed ____ Retired ____ On Strike ____ Disabled ____ Other ____
11. Wage Rate: $ _____ Per Day ____ Per Week ____ Per Month ____
12. Days worked per week: _____ 13. Did Employee receive full pay for day of injury? Yes ____ No ____
14. 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. Date employer was notified of occurrence: _____
6. Date disability began: _____

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7. Type of injury: _____
8. Part of body affected: _____
9. Did injury/illness/exposure occur on employers premises? Yes ____ No ____
10. Department or location where accident or illness/exposure occurred? _____
    _____
11. ZIP Code of injury site: _____
12. All equipment, materials or chemicals employee was using when accident or illness/exposure occurred:
    _____
13. Specific activity the employee was engaged in when the accident or illness/exposure occurred:
    _____
    _____
14. Work process the employee was engaged in when accident/illness/exposure occurred:
    _____
    _____
15. 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:
    _____
    _____
16. Date returned to work: _____
17. If fatal, give date of death: _____
18. Were safeguards or safety equipment provided? Yes ____ No ____
19. Were they used? Yes ____ No ____

MEDICAL PROVIDER

1. Name of Physician or Health Care Provider: _____
2. Address: _____
3. Name of Hospital or off-site treatment facility: _____
4. Address: _____
5. Initial Treatment (check one):
   No Medical Treatment ____ Minor/Treatment by Employer: ____ Emergency Care: ____
   Hospitalized greater than 24 hours: ____ Future major medical/lost time anticipated: ____

QUAL-LYNX
LINKING YOU TO QUALITY CLAIM SERVICES

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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: _____
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 unusually 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: _____

QUAL-LYNX
LINKING YOU TO QUALITY CLAIM SERVICES

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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? _____
18. Would you like to speak to any Fund Professional? Yes____ No____
    If Yes, please list: _____

Supervisor's Name: _____

Date: _____

Distribution: Claims Administrator
Safety Director
Safety Delegate
Your records

QUAL-LYNX

PO Box 1209, Piscataway, NJ 08855
Phone: 908-222-7500 Fax: 732-465-7355

SUPERVISOR REPORT – WORKERS COMPENSATION CLAIM

- SUBMIT AS A SUPPLEMENT TO THE ORIGINAL FIRST REPORT OF INJURY
- TO BE COMPLETED BY EMPLOYEE'S DIRECT SUPERVISOR

Supervisor Name: _____

Employer/Fund Member: _____

Address: _____

Phone: _____

1. Employee Name: _____
2. Department: _____
3. Date, Time and Location of Occurrence: _____
4. Type of Injury: _____
5. Do you usually supervise this individual? Yes ____ No ____
   If No, Explain: _____
6. Was accident immediately reported? Yes ____ No ____
   If No, Explain: _____
7. Was employee working: Alone _____ With Crew _____
8. Did you physically inspect the area where the injury occurred? Yes ____ No ____
   If No, Explain: _____
9. Any unsafe conditions or unusually hazards present? Yes ____ No ____
   If Yes, Explain: _____
10. Was employee wearing back support? Yes ____ No ____
    If No, Explain: _____
11. Evidence of horseplay: Yes ____ No ____
    If Yes, Explain: _____
12. Evidence of intoxication Yes ____ No ____
    If Yes, Explain: _____
13. Evidence of drug abuse Yes ____ No ____
    If Yes, Explain: _____
14. Are you satisfied that the accident/injury occurred as described above? Yes ____ No ____
    If No, Explain: _____
15. What additional training may have prevented this accident? _____
16. What additional training would you like Fund's Safety Director to provide? _____
17. What circumstances contributed to this accident? _____
18. What actions contributed to this accident? _____
19. What changes in circumstances or actions could have prevented this accident? _____
20. Your actions taken to minimize the chance of a recurrence? _____
21. Your future plans to minimize the chance of a recurrence? _____
22. Would you like to speak to any Fund Professional? Yes ____ No ____
    If Yes, please list: _____

SIGNATURE: _____

DATE: _____

WORKERS COMPENSATION INJURY/LOSS CODES

BODY PART	
010	MULT HEAD INJURY - HEAD
011	SKULL-HEAD
012	BRAIN-HEAD
013	EAR(S)-HEAD
014	EYE(S)-HEAD
015	NOSE-HEAD
016	TEETH-HEAD
017	MOUTH-HEAD
018	OTHER FACIAL TISSUE-HEAD
019	FACIAL BONES(inc jaw)-HEAD
020	MULT. NECK INJURIES-NECK
021	VERTEBRAE(inc cervical)-NECK
022	DISC(inc cervical segmnt)-NECK
023	SPINAL CORD(inc.cervicl)-NECK
024	LARYNX(inc.cartilage)-NECK
025	SOFT TISSUE(not trachea)-NECK
026	TRACHEA-NECK
030	MULT. UPPER EXTREMITIES
031	UPPER ARM,HUMERUS,MUSCLES
032	ELBOW-UPPER EXTREMITIES
033	LOWER ARM-UPPER EXTREMITIES
034	WRIST-UPPER EXTREMITIES
035	HAND-UPPER EXTREMITIES
036	FINGER(S)-UPPER EXTREMITIES
037	THUMB-UPPER EXTREMITIES
038	SHOULDER(S)-UPPER EXTREMITIES
039	WRIST & HAND-UPPER EXTREMITIES
040	MULT. TRUNK INJURIES-TRUNK
041	UPPER BACK AREA(THORACIC)
042	LOWER BACK(LUMBAR&LUMBOSACRAL)
043	DISC-TRUNK
044	CHEST(RIBS,SACRUM&SOFT TISSUE)
045	SACRUM & COCCYX-TRUNK
046	PELVIS-TRUNK
047	SPINAL CORD-TRUNK
048	INTERNAL ORGANS-TRUNK
049	HEART-TRUNK
050	MULT. LOWER EXTREMITIES
051	HIP-LOWER EXTREMITIES
052	UPPER LEG-LOWER EXTREMITIES
053	KNEE-LOWER EXTREMITIES
054	LOWER LEG-LOWER EXTREMITIES
055	ANKLE-LOWER EXTREMITIES
056	FOOT-LOWER EXTREMITIES
057	TOE(S)-LOWER EXTREMITIES
058	GREAT TOE-LOWER EXTREMITIES
060	LUNGS-TRUNK
061	ABDOMEN INCL. GROIN-TRUNK
062	BUTTOCKS-TRUNK
063	LUMBAR/SACRAL VERTEBRAE-TRUNK
064	ARTIF.APPLIANCE-MULT BODY PART
065	INSUFFICIENT TO CLASSIFY
066	NO PHYSICAL INJ-MULT BODY PART
090	MULT. BODY PARTS
091	MULT.BODY SYSTEMS

INJURY TYPE	
01	NO PHYSICAL INJURY
02	AMPUTATION
03	ANGINA PECTORIA
04	BURN
07	CONCUSSION
10	CONTUSION
13	CRUSHING
14	DEATH
16	DISLOCATION
19	ELECTRIC SHOCK
22	ENUCLEATION
25	FOREIGN BODY
28	FRACTURE
30	FREEZING
31	HEARING LOSS(TRAUMATIC ONLY)
32	HEAT PROSTRATION
34	HERNIA
36	INFECTION
37	INFLAMMATION
40	LACERATION
41	MYOCARDIAL INFARCTION
42	POISONING-GENERAL(NOT OD)
43	PUNCTURE
46	RUPTURE
47	SEVERANCE
49	SPRAIN
52	STRAIN
53	SYNCOPE
54	ASPHYXIATION
55	VASCULAR LOSS
58	VISION LOSS
59	ALL OTHER SPECIFIC INJURIES
60	DUST DISEASE-PNEUMONOCONIOSIS
61	ASBESTOSIS
62	BLACK LUNG
63	BYSSINOSIS
64	SILICOSIS
65	RESPIRATORY DISORDERS
66	POISONING-CHEMICAL
67	POISONING-METAL
68	DERMATITIS
69	MENTAL DISORDER
70	RADIATION
71	ALL OTHER OCCUP. DISEASE
72	LOSS OF HEARING
73	CONTAGIOUS DISEASE
74	CANCER
75	AIDS
76	VDT - RELATED DISEASE
77	MENTAL STRESS
78	CARPAL TUNNEL SYNDROME
79	HEPATITUS C
80	ALL OTHER CUMULATIVE INJURY
90	MULT PHYSICAL INJURIES ONLY
91	MULT INJURIES INCL PHYS/PSYCH

INJURY DESCRIPTION	
01	BURN/COLD EXPOSURE-CHEMICALS
02	BURN/COLD EXPOSURE-OBJ OR SUBS
03	BURN/COLD EXPOSE-EXTREME TEMPS
04	BURN/COLD EXPOSE-FIRE OR FLAME
05	BURN/COLD EXPOSE-STEAM/LIQUID
06	BURN/COLD EXPOSE-GASES/VAPORS
07	BURN/COLD EXPOSE-WELDING OPS
08	BURN/COLD EXPOSE-RADIATION
09	BURN/COLD EXPOSE-CONTACT WITH
10	CAUGHT IN/UNDER/BETWN MACHINE
11	BURN/COLD EXPOSE-COLD OBJ/SUBS
12	CAUGHT BY OBJECT HANDLED
13	CAUGHT IN,UNDER,BETWEEN,NOC
14	BURN/COLD EXPOSE AIR PRESSUER
15	CUT,PUNCTURE,SCRAPE/BRKN GLASS
16	CUT,PUNCTURE,SCRAPE/HAND TOOL
17	CUT,PUNCTURE,SCRAPE/HANDLE OBJ
18	CUT,PUNCTURE,SCRAPE/POWER TOOL
19	CUT,PUNCTURE,SCRAPE/NOC
20	CAUGHT IN,UNDER,BETWN,MATERIAL
25	FALL,SLIP,TRIP FROM ELEVATION
26	FALL,SLIP,TRIP FROM LADDER
27	FALL,SLIP,TRIP FROM LIQUID/GRS
28	FALL,SLIP,TRIP INTO OPENINGS
29	FALL,SLIP,TRIP FROM SAME LEVEL
30	SLIPPED, DID NOT FALL
31	FALL, SLIP, TRIP, NOC
32	FALL,SLIP,TRIP ON ICE OR SNOW
33	FALL,SLIP,TRIP ON STAIRS
40	MOTOR VEHICLE CRASH IN WATER
41	MOTOR VEHICLE-RAIL VEHICLE
45	MOTOR VEHICLE-MOTION COLLISION
46	MOTOR VEHICLE-CRASH FIXED OBJ
47	MOTOR VEHICLE-CRASH AIRPLANE
48	MOTOR VEHICLE-UPSET/OVERTURN
50	MOTOR VEHICLE-NOC
52	STRAIN/INJ BY CONTINUAL NOISE
53	STRAIN/INJURY BY TWISTING
54	STRAIN/INJURY BY JUMPING
55	STRAIN/INJURY BY HOLD/CARRY
56	STRAIN/INJURY BY LIFTING
57	STRAIN/INJURY BY PUSH/PULL
58	STRAIN/INJURY BY REACHING
59	STRAIN/INJURY BY TOOL/MACHINE
60	STRAIN/INJURY BY NOC
61	STRAIN OR INJ-THROWING/WIELDNG
65	STRIKE/STEP MOVING MACHINE PRT
66	STRIKE/STEP OBJ LIFTED/HANDLED
67	STRIKE/STEP SAND/SCRAPE/CLEAN
68	STRIKE/STEP ON STATIONARY OBJ
69	STEPPING ON SHARP OBJECT
70	STRIKING AGAINST/STEP ON NOC
74	STRUCK/INJ-FELLOW WORK/PATIENT
75	STRUCK/INJ-FALLING/FLYING OBJ
76	STRUCK/INJ-HAND TOOL/MACHINE
77	STRUCK/INJ BY MOTOR VEHICLE
78	STRUCK/INJ-MACHINE MOVING PRTS
79	STRUCK/INJ-OBJ LIFTED/HANDLED
80	STRUCK/INJ-OBJ HANDLED BY OTHR
81	STRUCK/INJ BY NOC(KICK,STAB)
82	MISC CAUSES-ABSORB,INJEST,NOC
84	BURN FROM ELECTRICAL CURRENT
85	STRUCK/INJ BY ANIMAL OR INSECT
86	STRUCK/INJ BY EXPLOSION
87	MISC CAUSES-FOREIGN BODY/EYES
88	NATURAL DISASTER
89	MISC CAUSES-ACT OF CRIME
90	MISC CAUSES-OTHR THAN PHYSICAL
94	RUBBED/ABRADED-REPEAT MOTION
95	RUBBED/ABRADED-NOC
96	TERRORISM
97	STRAIN/INJ.BY REPEAT MOTION
98	MISC CAUSES-CUMULATIVE,NOC
99	MISC CAUSES-OTHER-MISC,NOC

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