INJURY/ILLNESS INCIDENT REPORT

Send To: Email: info@agristaffservices.com
Fax: (609)601-5305

(Use the "Continuation Page" whenever additional space is needed. The word "injury", below, refers to both injury and illness.)

(Report is to be completed by designated Company Representative and (when feasible) the injured employee.)

CLAIM NUMBER:_____ (Assigned by the Person of Contact (POC) at the Call Center)

INJURED EMPLOYEE'S PERSONAL INFORMATION SECTION

NAME (Last; First; MI):_____ **SOC.SEC.No.**_____

STREET ADDRESS: _____ **CITY:**_____ **STATE:**____

COUNTY:_____ **ZIP CODE:** _____ **MALE:**_____ **FEMALE:**_____ **MARRIED:**____

DATE of BIRTH:_____ **AGE:**_____ **No. of DEPENDANTS:**_____ **DATE of HIRE:**_____

FULL TIME:_____ **PART TIME:**_____ **PAID HOURLY:**_____ **PAID WEEKLY:**_____ **AVG. WEEKLY PAY:**_____

OTHER PAY (explain):_____ **PRIMARY TEL. No.:**_____

CELLULAR No.:_____ **EMAIL ADDRESS:**_____

EMPLOYER'S INFORMATION SECTION

NAME of BUSINESS:_____

STREET ADDRESS:_____ **CITY:**_____ **STATE:**____

COUNTY:_____ **ZIP CODE:**_____ **EMAIL:**_____

TELEPHONE No.:_____ **EMPLOYER'S FEIN:**_____

EMPLOYER'S REPRESENTATIVE WHO COMPLETED THIS REPORT (NAME AND TITLE):

DATE	TIME

EMPLOYER'S CONTACT PERSON CONCERNING THIS REPORT (NAME, TITLE, TELEPHONE No. AND EMAIL ADDRESS):

INJURY INFORMATION SECTION

EMPLOYEE RECEIVE FULL PAY FOR DATE OF INJURY: Yes:____ No:____ IF "No", EXPLAIN:_____

TIME EMPLOYEE BEGAN WORKING ON DATE OF INJURY:_____ **IF FATAL, TIME OF DEATH:**_____

INJURY OCCURRED		INJURY REPORTED		MEDICAL ATTENTION		DISABILITY BEGAN		RETURNED TO WORK	
DATE	TIME	DATE	TIME	DATE	TIME	DATE	TIME	DATE	TIME

BODY PART(S) INJURED OR AFFECTED:_____

DESCRIPTION of HOW INJURY OCCURRED:_____

DID THE INJURY OCCUR ON EMPLOYER'S PREMISES: Yes____No____ If "yes", where on employer's premises:

IF THE INJURY DID NOT OCCUR ON THE EMPLOYER'S PREMISES, EXACTLY WHERE DID IT OCCUR:_____

WHAT CHEMICALS OR EQUIPMENT WERE BEING USED BY THE INJURED EMPLOYEE AT THE TIME OF THE INJURY:_____

SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED: Yes____No____ BEING USED AT TIME OF INJURY: Yes____No____

IF PROVIDED AND NOT BEING USED, WHY WERE THEY NOT BEING USED:_____

WAS THE INJURY WITNESSED:_____**(IF "YES", THE "WITNESS SECTION" on Page No. 3 MUST BE COMPLETED):**

I, the undersigned employee, do hereby affirm each and every declaration I've made in the above-referenced report of my injury or illness is true and correct to the best of my ability. I further affirm I have made the declarations of my own free will, without coercion, promises or enticements of any type. **I understand any payments made by my employer, in my behalf, is not an admission of guilt or liability on the part of my employer.** I authorize full and complete access to copies of medical records, radiology reports, drug/alcohol screenings and documents of any and all kind relating to my past or present illness or injury to Cornerstone Brokerage, LLC, and any representative of Cornerstone Brokerage, LLC. I voluntarily release this information, and hold any such medical providers harmless for the release of the information, in accordance with this authorization. I know that any falsification of information herein may result in my loss of Workers' Compensation Benefits in this matter, and that **"Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison."**

Printed Name of Employee:_____ **Signature of Employee:**_____

Employer's Representative Witnessing Employee's Signature:_____ **Date:**_____

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PHYSICIAN/HEALTH CARE PROVIDER INFORMATION

(Use the "Continuation Page" whenever additional space is needed. The word "injury", below, refers to both injury and illness.)

CLAIM NUMBER:_____ (Assigned by the Person of Contact (POC) at the Call Center)

MANDATORY DRUG SCREENING SECTION

MANDATORY Drug Screening was Performed: Date:_____ **Time:**_____ **Location Performed:**_____

If MANDATORY Drug Screening was NOT performed, why not:_____

INITIAL TREATMENT PROVIDED BY

None:___ **Injured Employee:**___ **Panel Physician:**___ **Injured Employee's Physician:**___ **Hospital/Medical Clinic:**___

Injured Employee admitted to Hospital: Yes___ **No**___ **Injured Employee Hospitalized over 24 Hours: Yes**___ **No**___

Specific reason given for Hospitalization:_____

Location and telephone No. of Hospital:_____

TREATMENT CENTER INFORMATION

NAME: _____

ADDRESS: _____

CITY; STATE; COUNTY; ZIP CODE: _____

TELEPHONE No.; FAX No.; EMAIL:

TREATMENT CENTER INFORMATION

NAME: _____

ADDRESS: _____

CITY; STATE; COUNTY; ZIP CODE: _____

TELEPHONE No.; FAX No.; EMAIL:

PHYSICIAN/HEALTH CARE PROVIDER INFORMATION

NAME: _____

ADDRESS: _____

CITY; STATE; COUNTY; ZIP CODE: _____

TELEPHONE No.; FAX No.; EMAIL:

PHYSICIAN/HEALTH CARE PROVIDER INFORMATION

NAME: _____

ADDRESS: _____

CITY; STATE; COUNTY; ZIP CODE: _____

TELEPHONE No.; FAX No.; EMAIL: _____

PHYSICIAN'S DETERMINATION OF INJURED EMPLOYEE'S AVAILABILITY FOR RETURN TO DUTY

FULL DUTY: Yes___ **No**___ **LIMITED (RESTRICTED) DUTY: Yes**___ **No**___ **NO DUTY AT THIS TIME: Yes**_____

IF PHYSICIAN INDICATES THAT INJURED EMPLOYEE MAY RETURN TO "LIMITED OR RESTRICTED" DUTY, EXPLAIN LIMITATIONS SET FORTH BY PHYSICIAN:_____

CALL CENTER POINT OF CONTACT ("POC") INFORMATION

TELEPHONE NUMBER THE EMPLOYER'S REPRESENTATIVE DIALED FOR THE CALL CENTER: _____

TIME CALLED:_____ **DATE CALLED:**_____ **NAME OF PERSON CONTACTED AT THE CALL CENTER:**_____ **NAME AND CONTACT INFORMATION FOR EMPLOYER'S REPRESENTATIVE WHO CONTACTED CALL CENTER:**_____

SPECIAL NOTES CONCERNING CONTACT WITH THE CALL CENTER AND THE CALL CENTER PERSON CONTACTED:_____

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WITNESS REPORT

(Use the "Continuation Page" whenever additional space is needed. The word "injury", below, refers to both injury and illness.)

(A separate Witness Report is to be completed on each and every "Witness" to the injury.)

CLAIM NUMBER:_____ (Assigned by the Person of Contact (POC) at the Call Center)

WITNESS' PERSONAL INFORMATION SECTION

NAME (Last; First; MI):_____ **Company Employee: Yes___No___**

MALE:___ FEMALE:___ PRIMARY TEL. No.:_____ **CELLULAR No.:**_____

STREET ADDRESS: _____ **CITY:**_____ **STATE:**____

COUNTY:_____ **ZIP CODE:** _____ **DATE of BIRTH:** _____ **AGE:**____

EMAIL ADDRESS:_____

WITNESS' DESCRIPTION OF INJURY

I, the undersigned "witness", do hereby affirm each and every declaration I've made in the above-referenced report of injury or illness is true and correct to the best of my ability. I further affirm I have made the declarations of my own free will, without coercion, promises or enticements of any type. I voluntarily present this information, and with this authorization, hold harmless any recipient of the information who uses or shares the information in any way. I know that any falsification of information herein may result in a criminal matter, and that **any person who knowingly presents a false statement for the fraudulent payment of a loss is guilty of a crime, and may be subject to fines and confinement in a state prison.**

Printed Name of Witness:_____ **Signature of Witness:**_____

Employer's Representative Witnessing Witness' Signature:_____ **Date:**_____

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CONTINUATION PAGE

(Use the "Continuation Page"(s) for any category of the report that requires additional space to properly report.)
(SPECIFICALLY IDENTIFY EACH RESPECTIVE CATEGORY FOR WHICH THE "CONTINUATION PAGE" IS UTILIZED.)
CLAIM NUMBER:_____ (Assigned by the Person of Contact (POC) at the Call Center)

I, the undersigned, do hereby affirm each and every statement I've made in this report is true and correct to the best of my knowledge. I know any falsification of information herein may result in a criminal matter, and that **any person who knowingly presents a false statement for the fraudulent payment of a loss is guilty of a crime, and may be subject to fines and confinement in a state prison. (NOTE: IF THE INJURED EMPLOYEE OR ANY WITNESS INDICATED ANYTHING THAT WAS INCLUDED IN THIS "CONTINUATION PAGE", THE EMPLOYEE'S OR WITNESS' SIGNATURE IS REQUIRED BELOW.)**

Printed Name of Employee:_____ **Signature of Employee:**_____

Printed Name of Witness:_____ **Signature of Witness:**_____

Employer's Representative Witnessing Signature(s) above:_____ **Date:**_____