



### Employee's Report of Injury

#### **Employee Information:**

Full Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Hired: \_\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_ SSN: \_\_\_\_\_

#### **Incident Information:**

Date of Incident: \_\_\_\_\_ Time of Incident: \_\_\_\_\_ AM or PM Time of Arrival to Work: \_\_\_\_\_ AM or PM

Location of Incident: Building: \_\_\_\_\_ Room # or Area: \_\_\_\_\_

Describe what happened just before the incident occurred (describe the activity, as well as the tools, equipment or material being used. Be specific.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What happened/How did the injury occur: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was the injury or illness (what part of the body was affected, be specific): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What object or substance directly caused the harm (if this question does not apply, leave it blank): \_\_\_\_\_

\_\_\_\_\_

Names of Witnesses: \_\_\_\_\_

\_\_\_\_\_

#### **Physician/Health Care Professional Information:**

If treatment was given away from the worksite, where was it given (name and address): \_\_\_\_\_

\_\_\_\_\_ Date of visit: \_\_\_\_\_

Were you treated in an emergency room? Yes \_\_\_\_ No \_\_\_\_ Were you hospitalized overnight? Yes \_\_\_\_ No \_\_\_\_

Signature of Injured Employee: \_\_\_\_\_ Date: \_\_\_\_\_



P.O. Box 2217  
Southeastern, PA 19399-2217  
610.254.9050  
Fax 610.254.9093



www.kingstree.net  
KTGINC@kingstree.net



## HIPAA Authorization to Release and Disclose Health Information

I, \_\_\_\_\_ authorize **The Kingstree Group, Inc.** to obtain and review copies of all records and/or information from providers, including all hospital, medical, diagnostic results, vocational and other related records as they pertain to my treatment, coordination of care and/or injury rehabilitation program. I authorize **The Kingstree Group, Inc.** to re-disclose, share or discuss the information received with all parties whom are or may be involved in any reimbursement aspect of my treatment and/or rehabilitation program, and to provide or coordinate treatment and/or rehabilitation services.

I understand that I have a right to revoke this authorization at any time by providing written notice to the service provider set forth above. I further understand that the revocation will not apply to information that has already been released pursuant to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that if I refuse to sign this authorization, **The Kingstree Group, Inc.** may not receive necessary medical information to provide services contracted by your employer.

I authorize that a copy of this authorization shall be considered valid as the original.

I understand that, upon request, I have a right to receive a copy of the authorization form after it has been signed. **The Kingstree Group, Inc.** retains the original and/or copy of the form.

Name : \_\_\_\_\_

DOB : \_\_\_\_\_

Address : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Injury : \_\_\_\_\_

Signature : \_\_\_\_\_

Date : \_\_\_\_\_

Please complete and return by fax to The Kingstree Group, Inc. at : (610) 254-9093

In accordance with the HIPAA (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT), this fax transmission contains protected health information for the sole use on the intended recipient. The information contained in this facsimile message and/or the documents transmitted are confidential and intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient or agent responsible to deliver it to the intended recipient, you are hereby notified that any examination, use, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by telephone at the below number, and return the original message to us at the below address via the U.S. Postal Service.

THANK YOU.



**MILLBROOK**  
CENTRAL SCHOOL DISTRICT  
Office of Business

Paige Emerson  
Principal Account Clerk

PO Box AA  
43 Alden Place  
Millbrook, NY 12545  
845.677.4200 x1110  
paige.emerson@millbrookcsd.org

## **Reporting Employee Related Injury/Illness**

In the event of an on the job injury or illness, all employees are required to report the illness or injury to their supervisor immediately. Failure to report your injury in a timely fashion may jeopardize your rights to receive Workers' Compensation benefits. If medical care is necessary, please inform the doctor or hospital/treatment facility that you were injured on the job and have them forward all medical reports and bills to:

Wright Risk Management Company, Inc.  
900 Stewart Ave, Suite 600  
Garden City, NY 11530

Do not pay the doctor or treating facility for any treatment relating to a Workers' Compensation injury. Workers' Compensation Insurance is provided for such payments.

Please complete all attached forms (Employee's Report of Injury and Kingstree Health Information Release) when reporting an on the job injury/illness and forward them to the Business Office immediately, to the attention of Paige Emerson. These forms are available in all buildings.

If you have any questions, contact the business office at 845-677-4200 ext. 1110.