PERQUIMANS COUNTY SCHOOLS
REPORT OF ACCIDENT/INJURY/ILLNESS/

(Must Be Completed immediately after the incident/accident or initial treatment (**NOT LATER THAN 2 BUSINESS DAYS**) and submitted with all other required documents to the Human Resources Department)

SECTION 1: EMPLOYEE INFORMATION (Employee Only)

Employee Name:_____ Date of Birth:_____

Home Address:_____ City:_____ State:_____ Zip code:_____

Home Phone Number_____ Last 4 digits of SSN:_____ Sex: ____F _____M Age:_____

Job Title:_____ School/Department:_____ □ Full Time____ □ Part Time _____

SECTION II: ACCIDENT INFORMATION AND EMPLOYEE STATEMENT (Employee Only)

Accident Date:_____Time of Injury:_____ Time Workday Began: _____ □ a.m. □ p.m.

Exact Location of Accident:

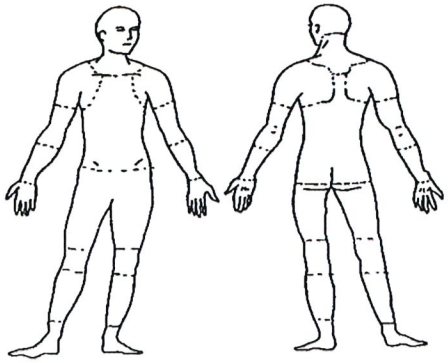
___ Bus # _____
___ Classroom # _____
___ Lunchroom
___ Restroom
__ Other _____
____ Hallway/Building _____
____ Media Center
____ P.E. Class / Gym
____ Play / School Grounds

Witnesses (Names) and (Departments)_____

What was the employee doing just before the accident occurred? Please be very specific :(Describe the activity, as well as the tools, equipment or material the employee was using. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."_____

_____

Bodv Part affected: (shade iniured area)



Full description of how injury occurred. What happened?
Please be very specific :(Tell us how the injury occurred. Examples:
"When ladder slipped on wet floor, worker fell 20 feet";
"Worker was sprayed with chlorine when gasket broke during replacement";
"Worker developed soreness in wrist over time.)

_____

_____

_____

What object or substance caused harm to the employee? _____

_____

What could have been done to prevent this injury/near miss?_____

_____

If the employee died, when did death occur:_____

Was First Aid Given on site? __yes ___no. Describe Aid Given: _____

_____

Was treatment given away from work site? __yes __no.

Doctor (check one):

___ NextCare Urgent Care - 615 S. Hughes Blvd, Elizabeth City, NC. Ph. 338-3111
___ Family Practice -Dr. Robert Lane - 600 S. Church St., Hertford, NC. Ph. 426-5711

Hospital (Only in case of Emergency)(check one):

___ Sentara Albemarle Medical Center (1144 N. Road St. Elizabeth City, Nc. Ph. 335-0531)
___ ECU Health Chowan Hospital (211 Virginia Road Edenton, Nc. Ph. 482-8451)

Was employee hospitalized overnight as an in-patient? _____yes _____no

Return to work date (as stated by physician) _____

Revised 02-01-12/Updates:D.Best 04-27-12/S.Winslow 3-8-18&05-23-18/D.Mallory 2-13-23

Employee's Statement (Refusal of medical treatment)

I, _____ have been given the opportunity to see a Physician. At this time I do not require medical attention, nor do I want to see a doctor.

I understand that if my condition changes in the near future I do have the right to obtain medical treatment but I also understand that my employer requires me to notify them if I need medical treatment at a later date and they will direct me to the physician that has been selected by my employer to treat workers' compensation injuries.

I further understand that if I seek medical treatment on my own without the approval of my employer I subject myself to having to pay for the medical treatment myself and that the workers' compensation carrier may not pay for my medical treatment under this circumstance.

EMPLOYEE CERTIFICATION

I hereby certify that the above referenced information is true and accurate. I further understand that the information above will be used by my employer to help determine compensability for my injury and that any inaccurate or false statements offered may result in a delay in processing my claim and/or my request for Workers' Compensation Benefits.

Employee Signature_____Date_____

SECTION III: PRINCIPAL/DIRECTOR

This accident was reported to me on: Date:_____ Time:_____ School/Department:_____

Was safety equipment provided? ☐ Yes ☐ No ☐ N/A Was safety equipment used? ☐ Yes ☐ No ☐ N/A

Principal's/Director's Signature:_____
Print Name:_____
Date:_____ Phone#:_____

Case Number from Log Form 300:_____

***Send Original to HR & Copy to District Safety Coordinator**

SECTION IV: HUMAN RESOURCES DEPARTMENT ONLY

Employment Hire Date:_____ Budget Code:_____

Salary:_____ Number of Hours Worked Per Week:_____

Number of days with restrictions: _____

Send Copy to Injured Employee (attach a blank copy of form 18 and copy of form 19) (dates/initial when sent)_____

Filed By Signature_____ Date_____

ATTENTION: This form contains information relating to employee's work-related injury and must be used in a manner that protects the confidentiality of the employee to the maximum extent possible.

PERQUIMANS COUNTY SCHOOLS

| Physician's Report |

MAILING ADDRESS: P.O. Box 337, Hertford, NC 27944
Phone: 252-426-5741 / Fax: 252-426-4913

EMPLOYER: Please complete the top section and give to the injured employee to take with them to their authorized treating physician. If you already have transitional duty job descriptions available, please attach a copy for the treating physician's review.

Name of Employee: **Last:**	**First:**
Date:	
Name of Employer:	
Principal/Director:	Treating Physician:

EMPLOYEE: Please take this form with you to your treating physician. Please have the physician complete the middle section and return this immediately to your employer.

AUTHORIZED PHYSICIAN, PLEASE COMPLETE

Diagnosis: _____

In accordance with this patient's physical capability, check all that apply:

( ) May resume work immediately, no restriction.
( ) May resume work immediately with the following restrictions:
( ) Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
( ) Light work (lifting less than 20 pounds)
( ) Medium work (lifting less than 50 pounds)
( ) Heavy work (lifting less than 100 pounds)
( ) Normal shift
( ) Limited hours: _____hrs per day
( ) Put items in numerical or alpha order
( ) Opening Stock
( ) List SDS Sheets and put in order
( ) Deliver packages
( ) Data entry on the computer
( ) Pick up trash
( ) Filing
( ) Organize/sort parts
( ) Clean tools
( ) Clean Bathrooms
( ) Paint, touch –up paint
( ) Dust
( ) Mailings
( ) Sort parts and/or supplies
( ) Sweeping floors
( ) Counting Stock
( ) Labeling
( ) Running small parts

In an 8 hour day, patient may:
Stand/Walk _____ (number of hours) Sit_____ (number of hours) drive_____ (number of hours)

Patient may use hands for repetitive:

_____ Single Grasping(Left) _____ Pushing & Pulling (Left) _____ Fine Manipulation(Left)
_____ Single Grasping(Right) _____ Pushing & Pulling (Right) _____ Fine Manipulation(Right)

Patient is able to:
Bend _____ (Frequently) _____ (Occasionally) _____ (Not at all)
Squat _____ (Frequently) _____ (Occasionally) _____ (Not at all)
Climb _____ (Frequently) _____ (Occasionally) _____ (Not at all)

( ) Patient may return to work at full duty on (date) _____
( ) Patient has a return appointment on (date) _____ at (time) _____

Please indicate any referrals that are required: _____

Physician's Signature	Date	Physician's Name (type or print)

APPROVED PHARMACY
Walgreen's
CVS
Wal-Mart

Revised 02-20-19 S. Winslow

myMatrixx®
good medicine for business

State of North Carolina Department of Public Instruction
Workers' Compensation Prescription Information

Employer:

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

	PUBLIC SCHOOLS OF NORTH CAROLINA State Board of Education | Department of Public Instruction
Employee Name:	
Group#:	10602859
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employee:

State of North Carolina Department of Public Instruction 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
