VICTORIA COLLEGE

ACCIDENT/INCIDENT REPORT

INSTRUCTIONS & INFORMATION

Steps to Follow for any incident/accident:

1) Upon witnessing or being involved in an accident or incident, contact Campus Security immediately.
2) Complete the following Accident/Incident Report.
3) Submit form to Campus Security within 24 hours.

For Employees Only:

- For employee accidents, please maintain the Claims Administrative Services contact information and Worker's Compensation Prescription Information sheet for future use. Should you require medical treatment and/or prescriptions, these documents will be required.
- Also, for employees, maintain the Election to use Paid Leave with Workers' Compensation Benefits form. You are required to complete this form and submit to HR informing us of how you chose to use your paid leave.
- Please refer to Employee Handbook for detailed instructions, under ***SAFETY AND SECURITY POLICIES AND PROCEDURES*** or click on the following link http://www.victoriacollege.edu/dept/hr/handbook/safety/index.html#injury

VICTORIA COLLEGE ACCIDENT/INCIDENT REPORT

Information about ill/injured person:

Date Reported: ______________________________

Name: ____ Age:_________

Address: ____ Sex: M___ F___

City/State/Zip: ____

Home Phone: __________________________________ Work Phone: ______________________________

Is ill/injured person: _______ Student _______ Visitor _______ Employee

Incident Information:

Date & Time of Incident: ____

Building/Location of Incident (be specific): ____

First Person(s) notified: ____

Describe incident including ill/injured person's account/chief complaint; if possible, indicate the part of the body affected. (Record **only** facts/direct observations; DO NOT draw conclusions regarding cause.):

____

____

____

____

General information on conditions of the area at the time of the incident/injury:

____

____

Were EMS or Police contacted: _______Yes _______ No

If yes, whom: ____

If Police were notified, name and badge number of attending officer:

____

Photos taken: _______ Yes _______ No (If yes, please attach photos.)

Describe briefly any assistance/care provided:

____

____

Witnesses:

Name: ____ Telephone: _____________________

Address: ____

Name: ____ Telephone: _____________________

Address: ____

Report completed by: ____

Position ____

Claims Administrative Services, Inc.
501 Shelley Drive • P.O. Box 7500 • Tyler, TX 75711
(903) 509-8484 • Fax (903) 509-1888
(800) 765-2412

Release date 08/25/00

A Tradition Of Excellence

Workers' Compensation Prescription Information

________________________________ **(employer):**

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

CAS Claims Administrative Services, Inc. *Our reputation for excellence is no accident.®*	Health Innovations
Employee Name:	
Group#:	10602583
Member ID (SSN):	
Date of Injury:	
Processor:	mymatrixx
Bin#:	014211
Day supply is limited to 7 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Employee:

CAS 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 60,000 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 the above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

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.

Victoria College

Employee Election to Use Paid Leave with Workers' Compensation Benefits

Name: ____
Employee ID# ____
Position: ____
Department/Campus: ____
Date of Injury: ____

This employee is absent from duty because of a work-related illness or injury beginning on ________________. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

Please select and complete at least one of the following. This information must be completed as you are confirming that the employee will receive full pay during this time and there will be no loss of wages.

A. _________ # of **days** of leave available OR
B. _________ # of **hours** of leave available OR
C. The date that available leave will expire on is:_________________

_______________________________________ ________________________
District Authorized Signature **Date**

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

_____ I choose to use only __________ days of available paid leave at this time.

_____ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or –injury wages. I further understand that my leave will continue to be used unless and until I communicate to the district a change in my decision.

_____ I choose **NOT** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from _Victoria College_ while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, after exceeding seven days of lost time, unless and until I communicate to the district a change in my decision.

____________________________________ _________________________________
Employee signature **Date**