SCOTTSDALE HEALTHCARE℠

John C. Lincoln HEALTH NETWORK
Honored by Experts. Honored to Serve.

Occupational Injury/Illness/Exposure

Instructions (injured worker)

- Report all hazardous conditions and near-misses to your supervisor immediately. Assist as requested in all incident investigations.
- Report all injury/incidents immediately and no later than 24 hours by completing all sections on the attached Worker's Report of Injury/Incident and Authorization for Release of Information. Send these forms to Scottsdale Healthcare or John C. Lincoln Workers Compensation departments. Addresses, faxes and emails are listed below and on the forms.
- Provide a copy to your supervisor.
- If **medical care** is required, visit Scottsdale Healthcare or John C. Lincoln's – Employee Health facilities. All services will be directed and referral request by Employee Health.
- If exposed to blood or bodily fluid, contact Employee Health immediately.
- If released to work with restrictions or placed off-work
  - Call Workers Compensation if your department **cannot accommodate your restrictions** or if you are placed off work.
  - Return to work requires a Medical Certification showing release from the attending medical provider. If off work for more than 7 calendar days, a drug screen clearance by Employee Health is also required prior to returning to work.

Workers Compensation Provider Network

Employee Health Locations:

Shea	**Osborn**	**Thompson Peak (TPK)**	**Deer Valley**	**North Mountain**
10200 N 92nd St, Ste 100 Scottsdale, AZ 85258 Ph: (480) 323-3818 Fax: (480) 323-3238	3501 N. Scottsdale Rd. Ste 231 Scottsdale, AZ. 85260 Ph: (480) 882-4770 Fax: (480) 882-4391	20401 N. 73rd St., Ste 255 Scottsdale, AZ 85255 Ph: (480) 323-1881 Fax: (480) 905-1136	19841 N. 27th Ave., Ste. 404 Phoenix, AZ 85027 Ph: (623) 879-5499 Fax: (623) 879-1550	9202 N. 2nd St. Phoenix, AZ 85020 Ph: (602) 870-6332 Fax: (602) 331-5822

Physical Therapy:

Shea	**Osborn**	**Thompson Peak TPK**
10200 N 92nd St, Ste 100 Scottsdale, AZ 85258 Ph: (480) 323-3465 Fax: (480) 323-3677	3134 N Civic Center Plaza Scottsdale, AZ 85251 Ph: (480) 882-6820 Fax: (480) 947-3159	20201 N Scottsdale Healthcare Dr, Ste 135 Scottsdale, AZ 85255 Ph: (480) 324-7409 Fax: (480) 324-7405

Contact Information

Scottsdale Healthcare	**John C. Lincoln Deer Valley**	**John C. Lincoln North Mountain**	**Claims Administrator CCMSI**
8125 N. Hayden Rd. Scottsdale, AZ 85258-5199 Ph: (480) 323-4544 Fax: (480) 882-5825 Workerscomp@shc.org	19841 N. 27th Ave., Ste. 404 Phoenix, AZ 85027 Ph: (623) 879-5499 Fax: (623) 879-1550	9202 N. 2nd St. Phoenix, AZ 85020 Ph: (602) 870-6332 Fax: (602) 331-5822	PO Box 27920 Scottsdale, AZ 85255 Ph: (480) 384-5930

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Worker's Report of Injury/Incident

Personal Information

Name (printed) _____ Employee # / Social Security # _____

Address _____ City _____ State _____ Zip _____

Wk Phone _____ Hm Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Job Information

Job Title _____ Dept Name _____

Work Status ☐ Staff member ☐ Volunteer ☐ Contract Date began work _____

Supervisor _____ Ext _____ Time Card Supervisor _____ Ext _____

Bi-weekly hours: ☐ Scottsdale Healthcare Employee ☐ John C. Lincoln Employee

Injury/Incident Information

Date of Injury/Incident _____ Date First Reported _____ Reported to _____

Time of Injury/Incident _____ ☐ AM ☐ PM Time Workday Began on Date of Injury/Incident _____ ☐ AM ☐ PM

Part of Body Injured (finger, hand, arm, leg) _____ Side of Body Injured ☐ Left ☐ Right

Add.of Injury/Incident (i.e., 7400 E Osborn, 9003 E Shea , 7400 E TPK ,250 E. Dunlap,19829 N. 27th) _____

Exact Location of Injury/Incident (i.e., hallway, stairway, patient room, nurse station, lab) _____

Object that caused injury/incident (i.e., wet floor, knife, scapel, needle, combative patient) _____

If contaminated sharp caused injury/incident state manufacturer and type of object (OSHA required) _____

Describe the Injury/Incident (i.e., strain to shoulder from lifting patient during transfer from bed to gurney, cut to thumb while slicing food)

_____

_____

Safety Information

Safety equipment in use at time of incident (i.e., respirator, gloves, face mask, Shoes for Crews) _____

Type of footwear worn at time of incident (i.e., tennis shoes, sandals, dress shoes, shoe covers) _____

At time of incident, were you working in your normal department? ☐ Yes ☐ No If no, where were you working: _____

Job task you were performing at time of incident _____ Is this one of your normal duties? ☐ Yes ☐ No

State how you feel this incident could have been prevented or could be prevented in the future _____

_____

Witness Information

Name, address, telephone of person(s) who saw the incident _____

_____

Medical Care

Did you seek medical treatment for injuries? ☐ Yes ☐ No If yes, first treatment date _____

First treated? SHC/JCL Emp Health: ☐ Osborn ☐ Shea ☐ TPK ☐ North Mountain ☐ Deer Valley

SHC/JCL ER: ☐ Osborn ☐ Shea ☐ TPK ☐ North Mountain ☐ Deer Valley ☐ Other _____

Were you hospitalized overnight as an in-patient for injuries? ☐ Yes ☐ No Hospital name, address _____

Statement and Signature

I have received, read, understand the Occupational Injury/Illness/Exposure Instructions and agree to the terms and conditions as outlined in policies AD1432 Workers' Compensation, AD1430 Leave of Absence, and AD1490 Light Duty. I make application for all benefits to which I may be entitled and I do hereby certify, with full knowledge that it is against policy to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete. Authorization to return to work will require medical release and drug testing through Scottsdale Healthcare or John C. Lincoln Employee/Corporate Health.

Signature of worker or worker's authorized representative **X** _____ Date _____

Scottsdale Healthcare Employees fax, mail or email
8125 N. Hayden Rd.
Scottsdale, AZ 85258-5199
Ph: (480) 323-4544, Fax: (480) 882-5825
workerscomp@shc.org

JCL DV Employees fax, mail or email
19841 N. 27th Ave. Ste. 404
Phoenix, AZ. 85020
Ph: (623) 879-5499 Fax: (623) 879-1550
Catalina.Jasso@jcl.com

OR

JCL NM Employees Fax, mail or email
9202 N. 2nd St.
Phoenix, AZ. 85020
Ph: (602) 870-6332 Fax: (602) 331-5822
Gina.Anderson@jcl.com

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Authorization for Release of Information

Patient Information

Name (printed) _____

Phone _____

Social Security Number _____

Date of Birth _____

Disability Beginning Date _____

Authorization

I authorize my physician and/or administrative and clinical staff to use and/or disclose protected health information to Scottsdale Healthcare and/or John C. Lincoln Workers Compensation. The protected health information to be used or disclosed is in relation to the disability date referenced above and is being used or disclosed to process a claim for benefits.

This authorization shall be in force and effect until the date that the above referenced disability ends.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of patient or patient's legal representative **X** _____ Date _____

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