VERNON TOWNSHIP – REPORT OF INJURY
1 – 800 – 293 – 9795

Name of Injured: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

SSN: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** M ☐ F ☐

Salary: $_____ ☐Annum ☐Hour ☐F/T ☐P/T ☐Volunteer **Date of Hire:** _____

Dept. Employed: _____ **Position:** _____
(Specify Volunteer Organization)

Date of Injury: _____ **Time:** _____ am☐ pm☐ **Time start work:** _____ am☐ pm☐

Body part injured: _____

Location of Injury (address): _____

What was employee doing when injury occurred: _____

_____

_____

Object or substance that directly injured employee: _____

Witness: _____ **Immediate treatment location:** _____

Employee's Pharmacy: _____ **Case Manager:** _____

Supervisor Notified: _____ **Treatment:** _____
Facility Sent to by CSG

Contacted CSG: _____ _____ _____
Date Time Person Advised

Notified Personnel Office: _____ _____ _____
Date Time Person Advised

In completing the Worker's Compensation Questionnaire above, I have been advised that P. L. 1998, Chapter 74, Laws of the state of New Jersey provides that persons who purposely and knowingly make false or misleading statements for the purpose of obtaining workers' compensation benefits may be guilty of a crime of the fourth degree and have civil liability for all damages, costs and attorney's fees.

Date: _____ **Employee's Signature:** _____

Claim No.: _____ **Case Manager Phone No.:** _____

IMPORTANT NOTICE: During treatment of your Workmen's Compensation injury, CSG must authorize ALL medical facilities. Do not take it upon yourself to seek medical treatment prior to contacting your Case Manager.