Gallagher Bassett Third Party Administrators
1 Huntington Quadrangle, Suite 4N01
Melville, NY 11747
Phone (800) 477-5343 Fax:(800) 748-6159

Print Form

INITIAL REPORT

COMPLETE SECTIONS A & B AND SUBMIT THIS FORM WITHIN 24 HOURS OF ACCIDENT TO:
Dionne Marshak - marshak@townofriverheadny.gov or Fax 631-727-6152

SECTION A SUPERVISOR

(Please print)

Injured Person:_____ Sex: M ☐ F ☐
Employer's or Volunteer District's Name:_____
Home address:_____ Apt. #_____
City:_____ State:_____ Zip:_____
Home phone #: (____)_____ SS#:_____ DOB:_____
Dept:_____ Job title:_____ Dept. code (see reverse side): _____

Volunteer ☐ Paid ☐ **If volunteer, who is your regular employer?**_____

Employer contact name: _____ Employer contact phone #: (____)_____

Date of Injury:_____/_____/_____ Time of Injury:_____ AM _____ PM Part-time ☐ Full-time ☐

Name of Witness: _____
Description of injury and how injury occurred: _____
_____
_____
Where did injury/accident occur? _____
_____
Describe medical treatment: _____
_____
_____

Has employee returned to work? Yes ☐ No ☐ Return to work date: _____/_____/_____ Actual ☐ Expected ☐
Weekly wage: _____ Will wages be continued during disability? Yes ☐ No ☐
Based on restriction, the employee will be assigned the following status: Full Duty ☐ Transitional Duty ☐

Supervisor:_____ Phone #:_____

Supervisor's Signature:_____ Date: _____/_____/_____

SECTION B EMPLOYEE

Medical Authorization Fraud Statement

In accordance with New York State law, I hereby authorize Gallagher Bassett (or its representatives) to be furnished with any information or facts regarding this injury only, including records, diagnosis, medical treatment and prognosis, estimates of disability, and recommendations for further treatment. This information is to be used for the sole purpose of evaluating and handling any claim and medical care as a result of the incident occurring on or about the above noted date and for no other purpose, now or in the future.
ANY PERSON knowingly and with intent to defraud any coverage provider files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Employee Signature:_____ Date: _____/_____/_____

SECTION C MEDICAL PROVIDER

Name of Facility: _____ Date: _____/_____/_____

New Injury / Illness ☐ Existing Condition ☐

Preliminary diagnosis:_____
Recommended work status: Full Duty ☐ Transitional Duty ☐ No Work ☐
Modified duty restrictions apply for: Lifting up to: _____lbs. Carrying limited to: _____lbs.
Pushing / Pulling limited to: _____lbs. No lifting ☐ No carrying ☐ No pushing / pulling ☐
Other restrictions or comments:_____
Follow-up appointment with:_____ Date: ____/____/____ Time: _____AM _____PM
Physician / Clinician name (please print): _____ Phone #: (____)_____
Physician / Clinician Signature:_____ Date: _____/_____/_____

F