



Gallagher Bassett Third Party Administrators

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

INITIAL REPORT

**COMPLETE SECTIONS A & B AND SUBMIT THIS FORM WITHIN 24 HOURS OF ACCIDENT TO:
Jean Miloski - miloski@townofriverheadny.gov or Fax 631-727-1768**

(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 A SUPERVISOR

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 B EMPLOYEE

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): _____ F _____ Phone #: (____) _____

Physician / Clinician Signature: _____ Date: ____/____/____

SECTION C MEDICAL PROVIDER