St. Lawrence-Lewis Counties
School District Employees-Workers' Compensation Plan
P.O. Box 646
Canton, NY 13617-0646
315-379-3000
TOLL FREE 1-800-722-0782

RELEASE OF INFORMATION

Authorization to release copies of medical records, diagnosis, prognosis, past history exams, and any other information requested by the Insurance Company.

*I, _____, hereby authorize you to release any information to the St. Lawrence-Lewis Workers' Compensation Plan that they deem necessary.

Patient's/Claimant's Signature: _____
Date: _____

EMPLOYEE'S REPORT OF ACCIDENT OR OCCURRENCE FOR WORKERS' COMPENSATION

NAME: _____ *DATE OF ACCIDENT:* _____

ADDRESS: _____ *TELEPHONE #:* _____

_____ *DATE OF BIRTH:* _____

SOC. SEC. #: _____ *NO. OF DEPENDENTS:* _____

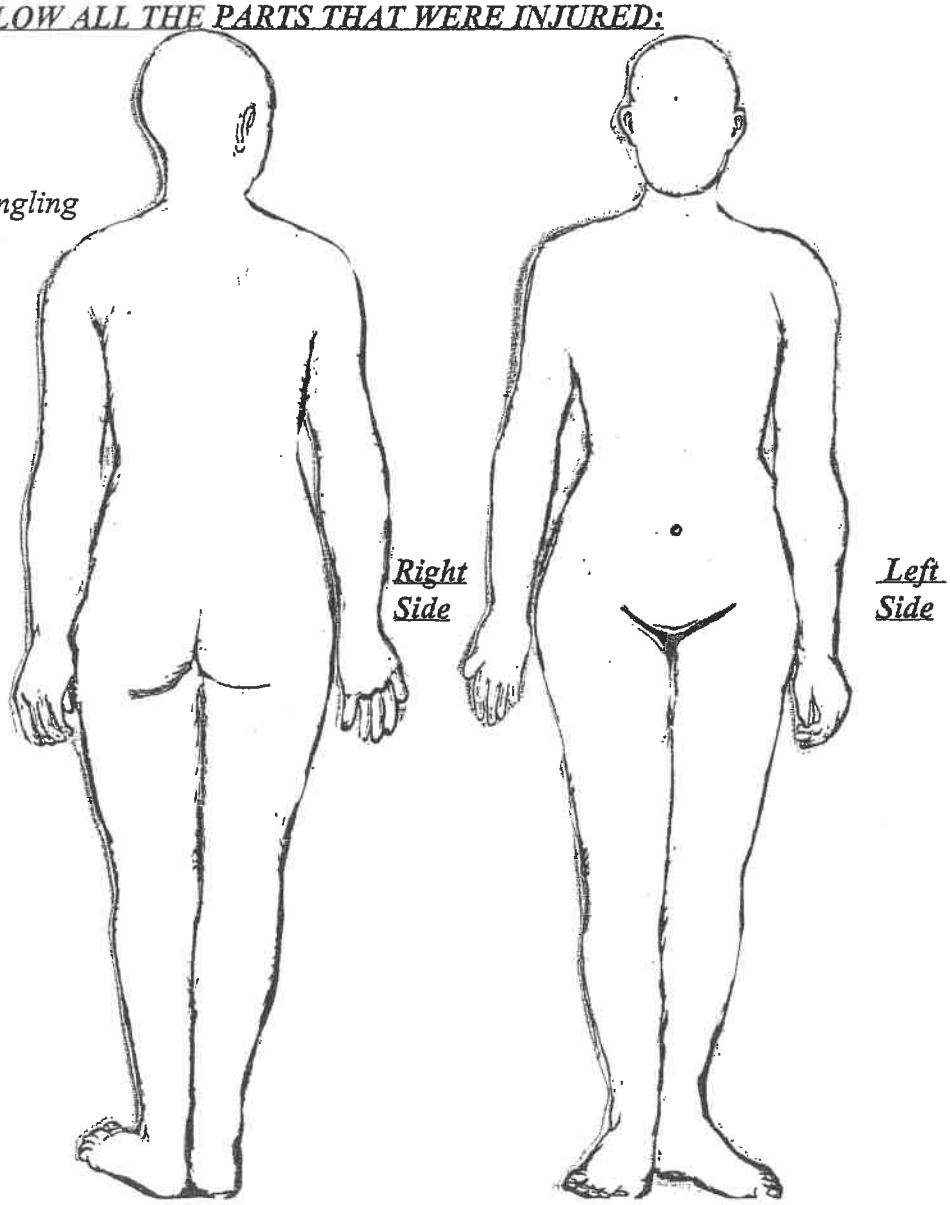
MARRIED OR SINGLE: _____

NAME OF SCHOOL: _____ *OCCUPATION:* _____

IMMEDIATE SUPERVISOR: _____ *DATE OF HIRE:* _____

PLEASE MARK BELOW ALL THE PARTS THAT WERE INJURED:

please mark with
//// for pain
.....for numbness or tingling
--- for cut
***for rash*



WERE YOU EVER TREATED FOR THIS CONDITION BEFORE? _____

WHAT DID YOU INJURE IN THE ACCIDENT OR OCCURANCE?: _____

PLEASE GIVE A DETAILED DESCRIPTION OF THE ACCIDENT OR OCCURENCE:

_____

_____

WERE THERE ANY WITNESSES TO THE ACCIDENT OR OCCURENCE: IF YES PLEASE GIVE NAMES AND ADDRESSES: _____

_____

DID YOU SEEK MEDICAL ATTENTION FOR THE INJURY OR OCCURENCE? IF YES, PLEASE GIVE NAME OF FACILITY AND ADDRESS: _____

_____

_____

DO YOU HAVE ANY PRE-EXISTING CONDITIONS OR AILMENTS, SUCH AS HIGH BLOOD PRESSURE, HEART CONDITIONS, DIABETES ETC? IF YES, PLEASE LIST THEM WITH THE NAME OF YOUR TREATING PHYSICIANS: _____

_____

_____

HAVE YOU EVER HAD ANY PREVIOUS WORK RELATED INJURIES? IF YES, PLEASE STATE THE INJURY, APPROXIMATE DATE OF ACCIDENT, AND EMPLOYER AT THAT TIME: _____

_____

HAVE YOU EVER BEEN IN A CAR ACCIDENT OR HAVE HAD ANY INJURIES AT HOME? IF YES, PLEASE STATE THE INJURY AND DATES AND PLACES OF THE ACCIDENT: _____

_____

DID YOU SEEK MEDICAL ATTENTION FOR ANY OF THE ABOVE? _____

_____

ARE YOU CURRENTLY WORKING FOR ANY OTHER ESTABLISHMENTS? IF SO, PLEASE STATE NAME, ADDRESS AND PHONE #: _____

_____

PLEASE LIST YOUR HOBBIES AND OUTSIDE ACTIVITIES: _____

_____

PLEASE GIVE THE NAME, ADDRESS AND PHONE NUMBER OF YOUR FAMILY PHYSICIAN:

_____

HAVE YOU EVER SEEN A CHIROPRACTOR IN THE PAST? IF YES, PLEASE LIST:

_____

HAVE YOU EVER BEEN HOSPITALIZED? IF YES PLEASE STATE DATE, NAME OF HOSPITAL AND REASON: _____

_____

EMPLOYEE'S SIGNATURE: _____ *DATE:* _____

ANY PERSON WHO, IN CONNECTION WITH A CLAIM FOR PAYMENT OR OTHER BENEFIT, PURSUANT TO AN INSURANCE POLICY OR SELF INSURANCE PROGRAM, KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO AN INSURER, SELF INSURER OR PURPORTED INSURER, OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT WHICH HE/SHE KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSES OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, MAY BE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO BE SUBJECT TO CIVIL LIABILITY.