Board of Cooperative Educational Services of Nassau County
71 Clinton Road, P.O. Box 9195
Garden City, NY 11530-9195

OFFICE USE ONLY

Case #: _____

AWW:_____

Attention: This form contains information relating to employee health and must be used in a manner that protects the Confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

EMPID # _____
SCHOOL YR _____

SECTION 1

Injured Employee (To be filled out by Employee or Supervisor) Submit this report within 24 hours of incident

Note: If employee is unable to sign report due to injury severity, report should be submitted without

SECTION 2

a. Description of injury/incident and Cause
(To be filled out by

(Attach sheets with

If employee has not yet returned to work, have the injured person inform Human Resources when he or she returns to work. The telephone number is (516) 396-2269.

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy bene ts under New York regulations for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please ll out the card based on the instructions below.

Injured Employee:

If you need a prescription lled for a work-related injury or illness, go to an Optum Tmesys ® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will ll your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To nd a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

PTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRA

PERMA

CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Call 1-800-964-2531 to establish First Fill bene t eligibility and obtain the ID number for online adjudication of approved bene ts for the injured worker.
Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.

Employer:

Immediately upon receiving notice of injury, ll in the information above and give this form to the employee.

The follow5a53sptr79.67999.es compris99.46232 wMa0tum Wmay also nd further information on the web atwcb.ny.gov.

tmesys®

IMP14-1614-260

State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

To the Injured Employee:

For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

employer is (i)
ovider organization (PPO) under Article 10-A of the
rticipating in the alternative dispute resolution (ADR)
he Workers' Compensation Law. In accordance with
mergency situations, you must obtain at least initial
on injury or illness from the certified network(s) or
q 1 0 0 1 45 657 cm 0 0 0 RG 0.6 46- j6- J 0 0 m 2331 -0.1sed

_____	_____	_____	_____
Signature of Injured Employee	Date	Signature of Witness	Date

To the Employer:

The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

Estado de Nueva York
JUNTA DE COMPENSACIÓN OBRERA

Aviso de Aceptación de Uso de Proveedor de Servicios o Red de Salud Recomendado por Patrono o Compañía de Seguros

Al Empleado Lesionado:

Para el tratamiento de su lesión o enfermedad relacionada con su trabajo, usted puede escoger cualquier médico, podiatra, quiropráctico o sicólogo (con referido de un médico autorizado) que esté autorizado por la Junta y que esté aceptando pacientes de la Junta de Compensación Obrera.

Usted debe firmar esta forma de consentimiento si decide escoger usar una "Red" o Proveedores que sean recomendados por su patrono o por el seguro ó permitir que su patrono seleccione un proveedor en su nombre. Usted puede, en cualquier momento en el futuro cambiar su proveedor de salud de compensación obrera.

_____	_____	_____	_____
Firma Empleado Lesionado	Fecha	Firma Testigo	Fecha

Nota: No es necesario que usted firme este documento, si su patrono (1) participa en la organización certificada de proveedor preferido (PPO) acuerdo bajo el Artículo 10 A de la ley de Compensación Obrera, o (2) participa en el programa piloto de de resolución de alternativas de disputa (ADR) bajo la sección 25(2-C) de la ley de Compensación Obrera. De acuerdo con estos programas establecidos por ley, que

Al Patrono:
El patrono deberá proveer al empleado lesionado antes mencionado con una copia de esta forma firmada y deberá conservar el original en los records del empleado, donde pueda ser inspeccionada por la Junta de Compensación Obrera en cualquier momento. Esta forma no deberá ser sometida a la Junta de Compensación Obrera, ni deberá ser procesada con anterioridad a la lesión o enfermedad del empleado.

La Junta de Compensación Obrera emplea y sirve a personas con impedimentos sin discriminar.

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Nassau BOCES
Department of Human Resources
71 Clinton Rd, PO Box 9195
Garden City, NY 11530-9195

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PUBLIC EMPLOYER RISK MANAGEMENT ASSOCIATION, INC. (PERMA)
POLICY#: WC 000152-00
INSURER ID W861223
9 Cornell Road
Latham, NY 12110
Phone: 1-888-737-6269
Fax: 1-877-737-6232