MUNICIPALITY OF MONROEVILLE

"Equal Opportunity Municipality"

Form 4000

Accident Report

Injured Social Security Number

1 Date of Report	2 Date of Injury	3 Time of Injury	4 Normal Starting Time	5 Date of Hire
6 If fatal Injury Give Date of Death	7 Date Employer Notified	8 Last Day Worked	9 Date Returned to Work	Full Pay for Day of Injury?
10 Employer **MUNICIPALITY OF MONROEVILLE**			11 Person Making Out this Report	
12 Employer Address: **2700 Monroeville Boulevard, Monroeville, PA 15146 Allegheny**			13 Employer Telephone Number **(412) 856-1000**	
14. Mailing Address- If Different from Above			15 Nature of Business-Type of MFG – Trade- Construction **Local Government**	
16 Employee Name: First Middle Last			17 Male Female	18 Home Telephone #
19 Employee Address – include County and Zip Code			20 Married Yes No	21 Number of Children under the age of 18
22 Date of Birth	23 Age	24 If under 18 certificate Number	25 Occupation for which Issued	
26 Occupation		27 Department or Division Regularly Employed		28 How long employed?
29 Place of Injury on Employer Premises Yes No		30 If NO exact Location – Street, County, and State Zip		
31 Mechanical Defect Yes No		32 Unsafe Act Yes No		
33 Were safeguards or safety equipment provided Yes No		34 Were safeguards or safety Equipment Used? Yes No		
35 Type of Injury		36 Part of Body Affected		
37 Witness Full Name			38 Witness Telephone Number	

What was employee doing when Injured? (Be Specific List all equipment, materials, or chemicals employee was using when accident or illness exposure occurred)_____

_____

_____

_____

How did the Injury Occur? Describe fully the sequence of events any objects or substances directly responsible?

_____

_____

_____

_____

_____

Nature and location of Injury or Disease (Describe Fully, Including body parts affected)

_____

_____

Initial Treatment:

_____ No Medical Treatment
_____ Minor by Employee
_____ Clinic/Hospital
_____ Panel Physician
_____ Employee Physician
_____ Emergency Care
_____ Hospitalized more than 24 hours

Physician/Healthcare Provider:

_____
Hospital Name

_____
Dr. First Name Dr. Last Name

_____
Address

_____
City, State Zip

NOTE: Medical Attention MUST be received from at least one of the Physicians or Hospitals on the Workers Compensation Doctors List posted in your department before any injury claim will be accepted.

Will Injury Require Use of Sick Leave? _____Yes _____No
Estimated Employee Recovery Time? _____Days _____Months

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

CHECK APPROPRIATE:

__X__ ENCOVA INSURANCE RECEIVE

I, the above named individual, authorize and direct all those listed below to release to The Workforce all information necessary to complete an evaluation of my medical status.

__X__ ENCOVA INSURANCE RELEASE

I, the above named individual, authorize The Workforce to release copies of my medical records to all those listed below.

INFORMATION TO BE RELEASED:

SUMMARY MEDICAL RECORDS including summaries, consults, staffing notes, and test results.
COMPLETE MEDICAL RECORDS.
SPECIFY OTHER:_____

THOSE TO RECEIVE/RELEASE INFORMATION:

1. **Encova Insurance, 400 Quarrier Street, Charleston, WV 25301 (866) 452-7425**
2. **Municipality of Monroeville, 2700 Monroeville Blvd., Monroeville, PA 15146 (412) 856-3306**

This authorization is valid for 90 days from the date of my signature and may be revoked at any time by my written request. I agree that a Photostat of this authorization be accepted with the same authority as the original.

_____ _____
Employee Signature Date

_____ _____
Department Head Signature Date

_____ _____
Director of Personnel Signature Date

_____ _____
Municipal Manager's Signature Date