D & H Alternative Risk Solutions
Worker's Compensation Claims
Via Email to: wcreportaclaim@risksolutions.com
or by fax 973-940-1852

D&H First Report of Injury (FROI) Report Form

Please email to: wcreportaclaim@risksolutions.com

REV 9/19

RECEIVED
2023 NOV 30 P 2:36
BOROUGH OF ROSELLE
OFFICE OF THE BOROUGH CLERK

Caller Information:

CALLER'S NAME AND TITLE: Nicholas Dorch			PHONE NUMBER: (973) 445-8916
WILL YOU BE THE CONTACT PERSON? IF NO, WHO WILL BE CONTACT PERSON?	YES / NO	CONTACT PERSON'S NAME:	CONTACT PHONE NUMBER:

Injury

DID THE INJURY OCCUR MORE THAN 3 DAYS AGO? (IF YES, WHY THE DELAY IN REPORTING) YES / NO ✓

REASON FOR DELAY:

Injured Worker Information

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOC. SEC. NUMBER	DATE OF HIRE
DORCH Nicholas	5-17-71	244-216	4/23

ADDRESS (INCLUDE ZIP): 128 E 9th St Roselle NJ.

SEX		MARITAL STATUS	
MALE	✓	M	MARRIED
FEMALE		U	SINGLE/DIVORCED UNMARRIED ✓
UNKNOWN		S	SEPARATED
		K	UNKNOWN

HOME PHONE NUMBER:	CELL PHONE NUMBER: 973 445 8916	# OF DEPENDENTS	EMPLOYMENT STATUS	OCCUPATION/TITLE: LABORER

RATE PER	HR / WK	DAYS WORKED/WEEK	HOURS WORKED/DAY	FULL PAY FOR DAY OF INJURY? 18 / DID SALARY CONTINUE?	YES / NO	YES / NO

Employer

EMPLOYER NAME: D.P.W

ADDRESS: (Include ZIP)

PHONE NUMBER:	FEDERAL TAX ID:

Employee Work Information

TIME EMPLOYEE BEGAN WORK	5 AM / PM	WHAT ARE HOURS THEIR NORMALLY SCHEDULED SHIFT?	5AM-11AM	WHAT DATE DID EMPLOYEE NOTIFY SOMEONE OF THEIR INJURY?	11/30/23

WHO WAS IT REPORTED TO? (NAME & TITLE)	T. Chadwick	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	YES / NO	WERE THEY USED?	YES / NO

IS THERE A REASON FOR THIS CLAIM TO BE PLACED UNDER INVESTIGATION? (If yes, list reason)

Occurrence/Injury

DATE OF INJURY	11/30/23	TIME OF INJURY	7:30 AM / PM	DID THE INJURY OCCUR ON THE EMPLOYER'S PREMISE'S?	✓ YES / NO

LOCATION/DEPARTMENT WHERE INJURY OCCURRED: On Street

DESCRIBE HOW INJURY OCCURRED:
I Bent Down to get garbage AND Lift to Put trash IN Truck And Lift my back started Having Sharp pain IN my Back garbage CAN had lot of wate

WHAT IS THE NATURE OF INJURY AND TO WHAT BODY PART?	BACK PAIN	Body Part	Left / Right	Upper / Lower

WAS THE INJURY FATAL?	YES / ✓ NO	DATE OF DEATH		DID EMPLOYEE SEEK TREATMENT?	✓ YES / NO

WHAT WAS THE MODE OF TRANSPORTATION TO THE PROVIDER?

HAS INJURED WORKER RETURNED TO WORK?	YES / NO	IF YES, RETURNED TO WORK DATE		IF NO, LAST DATE WORKED:	

Provider Name Address and Phone No.:	Was Injured Worker hospitalized for more than 24 hours: ☐ YES ☐ NO

Witness

Witness Name and Phone #

WORKERS' COMPENSATION

Employee Statement & Supervisor's Report of Accident

EMPLOYEE STATEMENT

Name Dorch Michaels Age 52 Phone (913) 4145 9416 SS # 244-21-6715
Address 128 E 9th St

What is your Job Title? LABORER What are your work hours? 5 to 11
Date of injury: 11-30-23 Time of injury:
Location of where injury occurred: ON STREET ROSELLE
Reason for being at that location: WORKING
Explain in detail exactly how the accident/injury occurred: I picked up GARBAGE CAN To empty it AND had WATER IN IT pulled something
Did anyone or anything contribute to this incident? Heavey CAN WATER IN it
Did anyone witness this incident? NOT SURE
Name: Job Title:
Name: Job Title:

List all body parts injured: BACK
Have you ever been treated for any of these body parts in the past? Yes (No)
If yes, provide the date(s) last treated: Did you require surgery? Yes (No)
Did you have an MRI or other diagnostic testing? Yes (No)
Are you employed elsewhere? Yes No If yes, where
Address
What do you do there? GARBAGE Hours: 6

Employee Signature Michaels Dorch **Date** 11/30/23

Supervisor Witnessing Signature **Date**

SUPERVISOR STATEMENT

Name TERRAIN CHANDLER Department DOR

Was the employee following their job description? Yes

Is additional training needed? Yes

Was the accident preventable?

Recommendation to prevent this type of accident in the future 1, ft with KNEES, AND GET PARTNER to help

Based on your knowledge of the incident, do you agree or disagree with employee's statement? Yes No

If you have additional information regarding this incident, after you have completed your inquiries, please provide same on a separate page and include the employee's name and date of injury.

Supervisor Signature **Date** 11/30/23

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SAFETY ACCIDENT REPORT

Name of Injured Employee: NICHOLAS DORCH

Address: 128 E 9th AVE Phone: (973) 445-8976

Age: 52 Sex: 244-21-6715 Social Security No: 244-21-6715

Place of Accident: Roselle

Time of Accident: 7:30 AM ____ PM Date of Accident: 11/30/23

Employed by: DPW

Address: 1121 Chandler AVE Phone: ____

Department: SAN Job Title: LABORER

Rate of Pay: 18.00 Hourly: 18.00 Weekly: B-C Other: ____

Immediate Supervisor: T. CHANCEY

Nature of Injury: Back

How did accident occur? LIFTING A GARBAGE CAN

Did injured accept treatment: ✓ or refuse treatment: ____

Name of Treating Doctor: ____

Address: ____

Name of Hospital: ____

Address: ____

Able to work: ☐ Yes ☑ No

If no, approximate length of time injured will be unable to work: ____

Was injured wearing:			
	Safety helmet	Yes ☐	No ☐
	Safety glasses	Yes ☐	No ☐
	Leather work gloves	Yes ☐	No ☐
	Safety work shoes	Yes ☐	No ☐
	Safety work vest	Yes ☐	No ☐

What was employee doing at the time he was injured? SANITATION TRUCK

Report prepared by: T CHANCEY / N DORCH

Reviewed by Department Head: T CHANCEY

Received by: [signature] Date: 11/30/23

9/23/2019
Rev. 06/10/2021

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Fax: (973) 940-1852

Verbiage below written by Nicholas Dorch

WITNESS REPORT

Name of Witness: _____ Department: _____

Address of Witness: _____ Phone number: _____ 4/30/23

Name of Injured: _____ Department: _____

Date of Accident: _____ Time: _____

In your own words, please describe in full detail how the accident occurred:

I WAS picking up TRASH CAN AN It had A lot of WATER IN It when I lifted it I pulled Muscle

_____ _____

Witness' Signature Date

UCHA
UNION COUNTY HEALTHCARE ASSOCIATES

11/30/2023

MD Care Urgent Center
637 Westfield Avenue
Elizabeth, NJ 072081621
Phone: 908-691-3800, Fax: 908-352-0505

Nicholas Dorch
05/17/1971
128 e 4th avenue East Orange, NJ 07017

To Whom It May Concern,

This note confirms that the above mentioned patient was seen in the office today for a medical evaluation and was found to be medically stable to return to work on

_____12/04/2023_____.

____X_____ With Restrictions

_____ Without Restrictions

Additional Comments:

Patient can return to work on 12/04/2023 on light duty as he can no be lifting heavy items - max 10 lbs for 1 week. Patient can return to regular duty on 12/11/2023.

Should you have further matters of question, please do not hesitate to call our office.

Sincerely,

Clara Irizarry, PA-C

MD Care Urgent Care
637 Westfield Ave
Elizabeth, NJ 07208

State of New Jersey

PRESCRIPTION BLANK

MD CARE URGENT CARE CENTER
637 WESTFIELD AVENUE
ELIZABETH, NJ 07208
TEL: 908-691-3800 • FAX: 908-352-0505

PRINT: Clara Irizarry PA-C / K. Tasharofa MD
NAME AND TITLE OF PRESCRIBER AND, IF APPLICABLE, COLLABORATIVE PHYSICIAN

LICENSE # _____ NPI # 1518474634

CHECK IF: ☐ APN ☐ CNM ☒ PA

LICENSE / CERTIFICATE / Rx AUTHORIZATION #

DEA # PRESCRIBER: _____

COLLABORATIVE PHYS: _____

PATIENT Dorch, Nicholas D.O.B. 5/17/71

ADDRESS _____ DATE 11/30/23

Rx

IF ISSUED BY AN OPTOMETRIST, NOT VALID FOR SCHEDULE II CONTROLLED DANGEROUS SUBSTANCES, EXCEPT FOR HYDROCODONE-CONTAINING PRODUCTS

Physical therapy
3 times a week
x 3 weeks

Dx: lumbago.

PSF160922000258

SUBSTITUTION PERMISSIBLE _____ DO NOT SUBSTITUTE _____

DO NOT REFILL ☒

REFILL _____ TIMES

SIGNATURE OF PRESCRIBER

Use a separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM INCLUDING ALTERATIONS OR FORGERY, ARE CRIMES PUNISHABLE BY LAW