RWJBarnabas HEALTH

WORK STATUS FORM

Employee name: Matthew Majkotoski Date: 2/14/23 Time: 11:49

Employer: Township of Irvington Date of Injury: 2/14/23

☒ Initial Work related injury or illness ☐ Follow up Work related injury or illness

☐ Return to work ☐ Fit for duty

☐ Other

WORK STATUS PLAN:

Work status recommendations remain in effect until the next evaluation

☐ **RETURN TO WORK FULL DUTY** date: _____

☐ **RETURN TO WORK MODIFIED DUTY** date: _____

Work modifications:

☐ Standing limited to _____ ☐ Pushing/pulling limited to: _____

☐ Sitting limited to _____ ☐ Lifting limited to _____ pounds

☐ No overhead work _____ ☐ No climbing _____

☐ No kneeling/squatting _____ ☐ Other _____

☑ **OUT OF WORK** *explanation:* 2-14-23 & 2-15-23

☑ **Return to Corporate Care appointment** 2-16-23 (Date) 8:30 AM (Time)

DIAGNOSIS: Right wrist Sprain & R Index Finger Sprain

INSTRUCTIONS:

☑ Rest _____ ☑ Ice/heat _____ ☑ Elevate _____

☐ Ace wrap/neoprene _____ ☐ Crutches _____ ☐ Aircast _____

☑ splint/brace _____ (R wrist) ☑ Other Aleve PRN c Food for pain

FOLLOW UP CARE

☐ Physical Therapy/Occupational Therapy _____

☐ Refer to (specialist physician): _____
Physician name

_____ Appt time and date _____ Physician phone number

☐ Discharged from Corporate Care

☐ Follow up with your personal physician _____

Provider Signature _____ Date 2-14-23

Provider Print Name Rosemary Ashley Burke

Time 12:36 AM/PM

I understand the instructions above. I will allow the release of the above information to my employer.

Employee signature _____ Date 2-14-23

Toll Free 855.286.2500 ■ www.occupationalmedicinenj.com

CM3307 (7/22)

Corporate Care/ Employee Health At:

Clara Maass Medical Center
Continuing Care Building,
1st Floor
1 Clara Maass Dr.
Belleville, NJ 07109
973.450.2175
Fax: 973.844.4779

Community Medical Center
Riverwood Plaza, Building 2,
2nd Floor
67 Rt. 37 West
Toms River, NJ 08755
732.557.8064
Fax: 732.557.8949

Cooperman Barnabas Medical Center
Atkins-Kent Building,
4th Floor - Suite 415
101 Old Short Hills Rd.
West Orange, NJ 07052
973.322.6450
Fax: 973.322.6460

Trinitas Regional Medical
240 Williamson Street
Suite 202
Elizabeth, NJ 07202
908.994.5368
Fax: 908.994.5623

Jersey City Medical Center
253 Monmouth St.
Jersey City, NJ 07302
201.885.4750
Fax: 201.521.2035

Monmouth Medical Center-Southern Campus
101 Prospect Street,
Suite 202
Lakewood, NJ 08701
732.942.5906
Fax: 732.942.5901

Monmouth Medical Center
300 Second Ave.
Long Branch, NJ 07740
732.923.6745
Fax: 732.923.6747

Newark Beth Israel Medical Center
201 Lyons Ave. @
Osborne Terrace
Newark, NJ 07112
973.926.7224
Fax: 973.926.3111

RWJ-Hamilton
2 Hamilton Health Place,
Hamilton, NJ 08690
609.631.6830
Fax: 609.689.7149

RWJ-New Brunswick
181 Somerset Street,
3rd Floor
New Brunswick, NJ 08901
732.937.8714
Fax: 732.418.8196

RWJ-Somerset
110 Rehill Avenue
Somerville, NJ 08876
908.685.2838
Fax: 908.685.2980

Other: _____

State of New Jersey

PRESCRIPTION BLANK

ROZANA ALLY, APN
RWJ BARNABAS HEALTH - CORPORATE CARE
101 OLDSHORT HILLS ROAD, SUITE 415 • WEST ORANGE, NJ 07052
PH. (973) 322-6450 FAX (973) 322-6460
NPI #1114479771

CERTIFICATION # 26NJ00678700 DEA # MA4102694

COLLABORATING PHYSICIAN

NAME RUTHANN KERR, MD LICENSE # 25MA05188300

(Enter Address and Phone Number only if different from above)

ADDRESS

PHONE #

PATIENT MAJ KOTOSKI D.O.B. 4-27-83

ADDRESS MATTHEW DATE 2-14-23

Rx

STAT

Right wrist, ē Ⓡ Hand x-rays

complete views

Attn | Ⓡ Ring finger

R/O FX - Osseous

SUBSTITUTION PERMISSIBLE DO NOT SUBSTITUTE Abnormal

DO NOT REFILL

REFILL ____ TIMES

SIGNATURE OF PRESCRIBER [signature]

Use a separate form for each controlled substance prescription

AEBHC1216000747

RWJBarnabas HEALTH

RWJBarnbas Health Corporate Care

Patient information

Name: MATTHEW MAJKOTOSKI Date of birth: 04/02/83 Social security number: 135-76-8885

Address: 106 Cameo Pl. (street) Phone number: _____

Colonia (City), NJ (State) 07067 (Zip) Cell phone number: 908.930.6306

Work information

Employer: Twp. of Irvington Job title: Captain

Supervisor: D/C Mulligan Supervisor phone number: 973-399-6582

If you are being evaluated for a work related injury, please complete the following section:

Date of injury: 02/14/2023 Time of injury: 04:30am Place of injury: 649 Grove St. Irvington, NJ 07111

Describe your injury: Swelling of wrist & hand

Have you received treatment for this injury? NO When? _____ Where? _____

Do you have another job? NO Type of job: _____ Full time? ____ Part time? ___

Please list your recreational activities (sports, crafts, construction, etc): N/A

Please list any volunteer activities: N/A

Have you had previous work-related injuries? If yes, please describe: None.

Have you ever had an MRI? no If yes, why was it done? _____

Have you ever consulted a chiropractor? no. If yes, what was the reason? : _____

MEDICATIONS: *please list*	**ALLERGIES:**	
None	NKA	

The information I provided is true and correct.

Signature

02/14/2023
Date

RWJBarnabas HEALTH

Attachment #3: **Employment Medical History Form** PATIENT HISTORY

Name: MATTHEW MAJKOTOSKI Date of Birth: 04/02/83 SS#: 135-76-8885

Full Address: 106 Cameo Pl. Colonia, NJ 07067

CELL phone # (908) 930-6304 (lab results) Home Phone # ( )

Email Address: Mmajkotoski@gmail.com

In case of emergency notify (Name): Lorraine Beecher-MAJKOTOSKI Relationship: wife

Full Address: S.A.A. Phone # (212) 365-8701

Medical History

Allergies: Seasonal

Do you now have or have you ever had any of the following? Check YES or NO. If yes, give year of occurrence.

	Yes	No	Year		Yes	No	Year		Yes	No	Year
Recurrent cough		✓		Rectal bleeding		✓		Back trouble		✓	
Coughing up blood		✓		Jaundice		✓		Neck trouble		✓	
Shortness of breath		✓		Leg pains		✓		Joint pains		✓	
Emphysema		✓		Ankle swelling		✓		Broken bones	✓		2012
Asthma		✓		Hernia		✓		Osteoporosis		✓	
Abnormal chest x-ray		✓		Urine problem		✓		Ear trouble, deafness		✓	
Tuberculosis History		✓		Cancer or tumor		✓		Eye/vision trouble		✓	
Dizzy spells		✓		Blood transfusion		✓		Nose trouble		✓	
Chest pain / Angina		✓		Blood disorder		✓		Throat trouble		✓	
Irregular heart beat		✓		Weight loss		✓		Kidney problem		✓	
Heart trouble		✓		Diabetes		✓		Skin problem		✓	
High blood pressure		✓		Seizures		✓		Arthritis		✓	
Fainting spells		✓		Headaches		✓		Prostate trouble		✓	
Frequent indigestion		✓		Paralysis		✓		Testicular trouble		✓	
Vomiting of blood		✓		Numbness, tingling		✓		Breast disorder		✓	
Hepatitis A		✓		Mental illness		✓		Stoke or TIA		✓	
Hepatitis B		✓		Drug/alcohol problem		✓		Brain/Neuro illness		✓	
Hepatitis C		✓		Latex/chemical sensitivity		✓		Past MRI tests		✓	
Gallbladder trouble		✓		Wheezing		✓		Other			

RWJBarnabas HEALTH

Attachment #3 (Continued): **Employment Medical History Form** PATIENT HISTORY

List any significant health issues not mentioned on the previous page: N/A

1. Alcohol- Yes / No (If yes, how much? _____)
2. Tobacco- Yes / No (If yes, how much? _____)
3. Prescription drugs- Yes / No (If yes, list on lines provided below.)

4. List ALL medications, both Prescription / Nonprescription:

N/A

5. List ALL past injuries-illnesses-surgeries-hospitalizations/Date:

"Boxers fracture" on right hand / Date: 2012

_____ / Date: _____

_____ / Date: _____

6. Have you been in a motor vehicle accident? NO Injuries? _____

7. Do you have a primary care physician? Yes / No.
   If yes, when was your last visit: _____
8. Previous occupation: EMT Transport
9. Prior Work Injury/Illness? Yes / No.
   If yes, describe: _____
10. Ever been rejected for employment, military service, or insurance for health reasons? Yes / No.
    If yes, describe: _____
11. Ever received Workmen's Compensation Benefits? Yes / No.
    If yes, describe: _____
12. Do you require Accommodation/special assistance? Yes / No.
    If yes, describe: _____

13 Do you use any aids/assistive devices (prosthesis)? Yes / No.
   If yes, describe: _____

I certify that all answers to the above questions are true, correct, and complete. I understand that any false, incomplete, or misleading information, may be considered sufficient grounds for immediate rejection or termination when discovered.

SIGNATURE of APPLICANT or guardian: _____ Date: 02/14/2023

RWJBarnabas HEALTH

RWJBarnabas Health Corporate Care

PLEASE FILL OUT THE ENTIRE PAGE. DO NOT LEAVE ANY OF THE SPACES BELOW BLANK.
IF THE ANSWER IS NO OR NONE, PLEASE WRITE SO.

PATIENT NAME: MATTHEW MAJKOTOSKI **D.O.B.:** 04/02/1983

Current Employer: Twp. of Irvington Employer Ph #: (973) 399 - 6562 Employer Fax #: (____) ____-____

Employer Address: 1 Civic Sq. Town: Irvington State: NJ Zip Code: 07111

How did the injury occur?: Stretching Fire hose Date and Time of Injury: 02/14/2023 @ 04:30 (AM)/PM

Date and Time the symptoms were first noticed: 04:30 (AM)/PM

Please describe your duties at work: Firefighter

Other employer: — Sports played: —

PREVIOUS EMPLOYERS	COMPANY NAME	JOB TITLE	PHONE NUMBER
1			

	NAME	ADDRESS	PHONE NUMBER	LAST VISIT
Primary Care Physician	Dr. Eisenstate	Union, NJ		unk
Pharmacy	Colonia Pharmacy	Colonia, NJ 07067		
Chiropractor				

Have you received treatment for similar symptoms before visiting this office? YES/(NO) *If yes, complete below:*

	DOCTOR/URGENT CARE/ CLINIC NAME	ADDRESS	PHONE NUMBER	TYPE OF TREATMENT
1				
2				

Have you had ANY surgeries? YES/(NO) *If yes, complete below:*

	DOCTOR/URGENT CARE/ CLINIC NAME	HOSPITAL	DATE	TYPE OF SURGERY
1				
2				

Have you had EVER been involved in a motor vehicle accident? YES/(NO) *If yes, complete below:*

	DOCTOR/URGENT CARE/ CLINIC NAME	HOSPITAL	DATE	INJURY AND TYPE OF TREATMENT
1				
2				

I HAVE REVIEWED THIS FORM AND HAVE NOTED ANY CHANGES.
TO THE BEST OF MY KNOWLEDGE, I BELIEVE ALL INFORMATION ON THIS FORM TO BE TRUE.

PATIENT SIGNATURE: [signature] DATE: 02/14/2023

RWJBarnabas HEALTH

RWJBarnabas Health Corporate Care

Please fill out this ENTIRE page. Thank you.

Name: MATTHEW MAJKOTOSKI **Date:** 02/14/2023 **DOB:** 04/02/83

SSN: 135 - 76 - 8885 **Cell #:** (908) 930 - 6304 **Home #:** (____) ____ - ____

Patient Address: 106 Cameo Pl. **Town:** Colonia

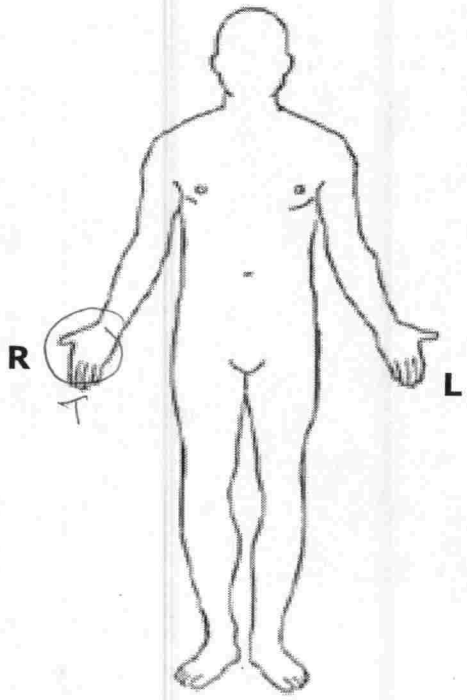
State: NJ **Zip:** 07067

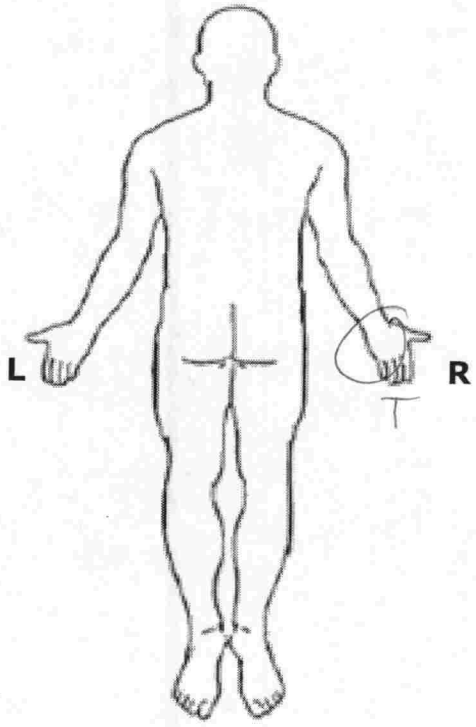
Pain Diagram

Please circle all of the injured areas of your body below. Please only circle areas from this date of injury only.

Next to each circled area, please use the corresponding codes to describe the sensations felt.
A = ACHE B = Burning N = Numbness P = Pins & Needles S = Stabbing T = Throbbing

Next to each circled area, please rate your pain from 0 to 10 with a numerical value.
0 = No pain/discomfort - 10 = the worst pain in your life.





Patient's Signature: _____

Saint Barnabas Medical Center
Barnabas Health

PATIENT'S NAME: _____

MR# _____

PT# _____

SEX _____ AGE _____

(AFFIX LABEL)

GENERAL CONSENT: INPATIENT, OUTPATIENT & EMERGENCY DEPARTMENT

1. **ADMISSION CONSENT:** I request and authorize Saint Barnabas Medical Center, Attending Physician and such associates, assistants and/or residents as may be selected by the said physician to provide such hospital care and to administer such routine diagnostic, radiological and/or therapeutic procedures and treatment including, but not limited to, the administration of pharmaceutical products, and intravenous medication, as in the judgement of the above physician(s) they deem necessary or advisable in my diagnosis, care and treatment. I am aware that the practice of medicine and surgery is not an exact science and I understand that no guarantee or assurance of beneficial results has been promised or implied as a result of the above-mentioned diagnostic and therapeutic procedures. I certify that I have read and fully understand this consent for diagnostic and/or therapeutic procedures and treatment. I understand that Saint Barnabas Medical Center is a teaching hospital and that medical students and residents may participate in my care and treatment. I understand that no guarantees have been made to me about the outcome of this care.
2. **MATERNITY DIVISION:** If I am admitted to have a baby, this consent shall also apply to the admission and Hospital treatment of the baby(ies) who is/are delivered by me during the hospitalization.
3. **RECURRING VISITS:** If the services rendered qualify me for recurring status, my signature hereon shall be valid for care rendered throughout this period. If, during this period, any of my registration information changes, i.e. address, phone, employment, insurance, guarantor, etc., I will notify the department where the registration originated of the change.
4. **RELEASE FROM RESPONSIBILITY FOR PATIENT'S VALUABLES:** I hereby certify that I have been advised and fully understand that Saint Barnabas Medical Center and its employees are not responsible for any and all personal articles, clothing or cash that I retain in my possession or on my person while a patient in the hospital. I acknowledge being advised not to retain more than $5.00 cash and to deposit valuables in excess of that amount for safekeeping with the hospital.
5. **RELEASE OF INFORMATION:** I understand that my medical records are kept in both hard copy and electronic form and that physicians and persons involved in my care have access to both forms of records. This may include remote access to electronic records from physician offices. The Medical Center may access electronic information about me from pharmacies I use, including prescriptions to treat AIDS/HIV, mental health issues, substance abuse and sexually transmitted diseases, if applicable. The pharmacy information will become part of my hospital medical record. I understand that if I do not wish the Medical Center to access my pharmacy information, I must submit a written request to the Medical Center's Privacy Officer. The Medical Center also participates in electronic health information exchanges (HIEs) with various other health care providers. I authorize the Medical Center and the HIEs with which it participates to share my health information, through the HIE networks, for purposes permitted by law, including my treatment and coordination of my care, with all health care providers that are authorized under the HIEs' policies and applicable law to access my information. I understand and agree that the information about me that may be shared and accessed through the HIEs may include information about HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, use of alcohol and other substances and other sensitive categories of my health information. I understand that I have the right to "opt-out" of having my information shared through HIEs, and instructions on how to do that can be found in the Notice of Privacy Practices, or may be requested from the Medical Center's Privacy Officer. The Medical Center may seek, release and verify all or part of my medical and/or financial records to any person, corporation, or government agency which is or may be liable under a statute, regulation, or contract to the hospital, the patient, a family member, or employer of the patient, for all or part of the Medical Center's charges. I consent to the release of medical information for purposes of discharge planning. I consent to the release of my identification, general condition and room telephone number. I understand that limited information about me will be utilized for Medical Center patient satisfaction surveys. I acknowledge that I have the right to designate a Caregiver.
6. **FINANCIAL AGREEMENT:** For and in consideration of services rendered, I agree to make prompt payment to Saint Barnabas Medical Center (SBMC) when billed for any and all charges not covered by valid insurance benefits. I understand that I am responsible for any health insurance deductibles, copayments, and/or coinsurance. If I am classified as a self-pay patient, a deposit will be requested. **I realize it is my obligation to obtain a referral, pre-certification or a second opinion should it be required prior to services.** If SBMC, or my insurance carrier, or its intermediaries, or the Quality Improvement Organization deems that medical and/or professional services to be given or already given are not medically necessary and/or non-covered services, I must pay for those services deemed patient responsibility. I grant permission and consent to Barnabas Health, assignees, and third party collection agents (1) to contact me by phone at any number associated with me including wireless cell numbers, (2) to leave answering machine and voicemail messages for me and include in any such messages, information required by law (including debt collection laws) and/ or regarding amounts owed by me (3) to send me text messages or emails using any email addresses I provide and; (4) to use pre-recorded/ artificial voice messages and/or an automatic dialing device (an auto-dialer) in connection with any communications made to me or any related scheduled services and my account. I HAVE CHECKED ALL DEMOGRAPHIC INFORMATION AND IT IS ACCURATE. **I understand that the Hospital will not deny emergent or urgent treatment and/or admission based on my, or the patient's, inability to pay.**
7. **AUTHORIZATION FOR TESTING:** In the event that any healthcare provider or first responder (including emergency medical service workers and police officers) involved in my care is exposed to my blood or bodily fluids and makes a request for testing and results of such testing, I consent to the drawing of blood for the purpose of testing it for various blood-borne pathogens including, but not limited to, Human Immunodeficiency Virus (HIV) and Hepatitis B and C. I understand and agree that the results of the blood test shall be released to me and the healthcare provider/first responder exposed to my blood or bodily fluids. To the extent possible, these results will be provided to the healthcare provider/first responder without disclosing my name.
8. **ASSIGNMENT OF BENEFITS:** I hereby assign, transfer and sign over to Saint Barnabas Medical Center all and sufficient monies, claims and/or benefits to which I may be entitled from governmental agencies, insurance carriers, union welfare funds or any other parties that are financially liable to pay the charges for the care, treatment and supplies that I was rendered and furnished or that were rendered and furnished to the patient for whom I have financial responsibility.
9. **FINANCIAL ASSISTANCE:** I have received a copy of the notice of Financial Assistance (back of patient copy of consent) and reduced Charge Financial Assistance. I understand I may be eligible for Hospital Care Payment Assistance or other forms of financial assistance but must apply to receive it.
10. **SAINT BARNABAS MEDICAL CENTER RELATIONSHIP TO CERTAIN PHYSICIANS AND PHYSICIAN GROUPS:** I understand that most of the physicians on the staff at Saint Barnabas Medical Center are not agents, servants or employees of the Saint Barnabas Medical Center but, rather are members of its Medical Staff who have been granted the privilege of using its facilities for the care and treatment of their patients. Saint Barnabas Medical Center contracts with independent groups of specialized doctors, who are neither employees nor agents of the Saint Barnabas Medical Center and are separate from the hospital and your private physicians. As such, the Saint Barnabas Medical Center has no direct or indirect liability for any act or omission of these groups or any physician, practitioner, or other employee associated with such groups. These groups may include, without limitation, the group staffing the Emergency Department, Radiology Department, the Laboratory Department, Radiation Oncology, Anesthesia and other physicians called upon to interpret certain diagnostic tests (e.g., EDG's, Echocardiographs, etc.).
11. **MEDICARE-AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or my physician(s) any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physicians or organization to submit a claim to Medicare for payment to me. THE SERVICE I RECEIVE MAY NOT BE COVERED BY MY MEDICARE INSURANCE. IN THE EVENT, I WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

ADVANCE DIRECTIVE:

I have an Advance Directive/Living Will/Health Care Agent	☐ YES	☒ NO	☐ UNKNOWN	☐ Under 18
I would like Advance Directive Information	☐ YES	☒ NO	☐ UNKNOWN	
I am providing a copy to Saint Barnabas Medical Center	☐ YES	☒ NO	☐ UNKNOWN	☐ Requested Copy

- I acknowledge receipt of the "Important message from TriCare" (back of patient copy of consent) My signature only acknowledges my receipt of this message and does not waive any of my rights to request a review or make me liable for payment.
- I acknowledge receipt of the Patient's Bill of Rights.
- I have been advised of my right to an Advance Directive.
- I understand that if I do not comply with the pre-certification requirements, I will be responsible for hospital charges.
- I acknowledge receipt of the "Privacy Notice."
- I acknowledge receipt of Physician and Physician Group Relationship and Related Billing Information.
- I have read this form, my questions have been answered, and I understand and agree to its content.

_____ Patient Signature/Authorized Representative

_____ Relationship

02/14/2023 Date

_____ The Patient is unable to sign because:

_____ Witness to signature only

42116 (REV 6/15)

MEDICAL RECORDS

RWJBarnabas HEALTH

DEMOGRAPHICS

PLEASE PRINT CLEARLY:

NAME: MATTHEW MAJKOTOSKI

SOCIAL SECURITY NUMBER: 135-76-8085

DATE OF BIRTH: 04/02/1983 **AGE:** 39

ADDRESS: 106 Cameo Pl.

CITY: Colonia **STATE:** NJ **ZIP:** 07067

PHONE: (C) 908-930-6306 **(H)** _____

B.

EMPLOYER: Twp. of Irvington **(W)** 973-399-6601

ADDRESS: 1 Civic Sq.

CITY: Irvington **STATE:** NJ **ZIP:** 07067

DEPARTMENT: Public Safety (F.D.) **JOB TITLE:** Firefighter

SUPERVISOR/MANAGER: D/C Mulligan **PHONE #:** 973.399.6592

CLAIM #: _____

WORKER'S COMP. INSURANCE:

_____