Three steps to follow if you are injured while at work:

1. Report your injury to your supervisor.
2. Call to speak to a Registered Nurse.
3. Provide employer TCC account number to the nurse.

TUNKHANNOCK AREA SCHOOL DISTRICT

TCC Number: 101165

TeleCompCare®

866-323-4227

AccidentFund.com/TeleCompCare

UnitedHeartland.com/TeleCompCare

CompWestInsurance.com/TeleCompCare

3CU.com/TeleCompCare

TeleCompCare® Workflow

Workplace Injury

Need to speak with a triage nurse?

Call TeleCompCare Nurse Triage

866-323-4227

For Spanish, press #9

Employee must provide

Employer Name: TUNKHANNOCK AREA SCHOOL DISTRICT

TCC Account Number: 101165

Employer Address:

Report claim only (No nurse intervention)

Nurse Triage with Employee

Self-Care

- Triage nurse will provide self-care instructions to employee
- Employee will receive text message with care instructions
- Employee returns to normal working duties
- Nurse will offer to follow up with employee within 24 hours to confirm symptoms improved

Clinic Referral

- After speaking with nurse, the employee is transferred to an agent who assists with locating a preferred provider
- In provider panel states, employee will be instructed to follow up with their supervisor

Telemedicine

To use this option, the employee must have a personal email address and device with audio/video

- After speaking with a nurse, employee is transferred to an agent who can assist with telemed application
- Physician reviews triage notes while employee creates personal login for appt.
- Any DME, imaging or PT will be scheduled with employee
- Any prescription orders are sent directly to pharmacy
- Return to work note emailed to employer

Options:

- Report claim via brand website portal
- Call TCC triage line, press option #2 and provide employer policy number

First notice of loss entered into claim system by staff member

*If applicable, employer directs employee to complete post-accident drug test

- Triage report sent to employer via email
- Triage data electronically received into claim system to create new claim

AFGroup.com

AF Group

AccidentFund
Insurance Company of America
Part of the AF Group

Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

FACILITY

NAME	CITY	STATE	LOCATION #

EMPLOYEE

NAME	SEX	D.O.B.	HEIGHT	WEIGHT
		/ /		

SOCIAL SECURITY #	HIRE DATE	FULL TIME	PART TIME	SHIFT: DAY	EVENING	NIGHT
— —	/ /	☐	☐	☐	☐	☐

DEPARTMENT	ADDRESS

JOB CLASSIFICATION	CITY, STATE	HOME PHONE #
		( )

DESCRIPTION OF ACCIDENT

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT LOCATION
/ /	: a.m. ☐ p.m. ☐	

Please describe the accident, including what employee was doing when it occurred.

Name object or substance that directly attributed to the accident.

What caused the accident? How could it have been prevented?

Describe the injury.

BODY PART

☐ 1. Abdomen	☐ 13. Forearm(s)	☐ 25. Ribs
☐ 2. Ankle(s)	☐ 14. Groin	☐ 26. Shoulder(s)
☐ 3. Back	☐ 15. Hand(s)	☐ 27. Spine
☐ 4. Buttock(s)	☐ 16. Head	☐ 28. Stomach
☐ 5. Calf(s)	☐ 17. Hip(s)	☐ 29. Teeth
☐ 6. Chest	☐ 18. Jaw	☐ 30. Thigh(s)
☐ 7. Ear(s)	☐ 19. Knee(s)	☐ 31. Throat
☐ 8. Elbow(s)	☐ 20. Leg(s)	☐ 32. Thumb(s)
☐ 9. Eye(s)	☐ 21. Lungs	☐ 33. Toe
☐ 10. Face	☐ 22. Mouth	☐ 34. Upper Arm(s)
☐ 11. Finger(s)	☐ 23. Neck	☐ 35. Whole Body
☐ 12. Foot	☐ 24. Nose	☐ 36. Wrist(s)

TYPE OF CONDITION

☐ 1. Abrasion	☐ 13. Grinding Wound	☐ 25. Repetitive Motion Disorder
☐ 2. Amputation	☐ 14. Hearing Loss	☐ 26. Scratch
☐ 3. Avulsion	☐ 15. Heart Attach	☐ 27. Sliver
☐ 4. Blister	☐ 16. Heat (cramps, stroke)	☐ 28. Splinter
☐ 5. Burn	☐ 17. Hernia	☐ 29. Sprain/Strain
☐ 6. Contusion	☐ 18. Infection	☐ 30. Slip/Fall
☐ 7. Death	☐ 19. Insect Bite	☐ 31. Other _____
☐ 8. Dermatitis	☐ 20. Irritation (dust)	
☐ 9. Foreign Object	☐ 21. Irritation (vapor)	
☐ 10. Fracture	☐ 22. Laceration	
☐ 11. Frostbite	☐ 23. Pulmonary Condition	
☐ 12. Ganglion	☐ 24. Puncture Wound	

Corrective actions taken to prevent reoccurrence.

Treatment

- ☐ *First Aid*
- ☐ *Panel of Physicians*
- ☐ *Emergency Room*
- ☐ *Personal Physician/Clinic*
- ☐ *Refused Treatment*
- ☐ *Other (name)*

Lost Time?	*Number of Days:*	*Modified/Restricted Duty*	NUMBER OF DAYS
☐ *Yes* ☐ *No*		☐ *Yes* ☐ *No*	

Did employee accept medical treatment?	*Was employee hospitalized?*	*Did employee return to work the same day?*
☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*

Report Date	**Employee Signature**	**Supervisor Signature**
/ /		