Opra

From: Thomas Cusick
Sent: Tuesday, April 20, 2021 3:27 PM
To: Opra
Subject: Fw: OPRA request - EMS reports

From: William Agar Jr <opra+request-21897-89a97d9b@requests.opramachine.com>
Sent: Monday, April 19, 2021 9:39 PM
To: Thomas Cusick <thomas.cusick@keansburg-nj.us>
Subject: OPRA request - EMS reports

Dear Keansburg Borough,

This is a request for public records made under OPRA and the common law right of access. I am not required to fill out an official form. Please acknowledge receipt of this message.
Records requested:
All copies of EMS reports/run sheets and accident/injury reports filed by EMS members detailing the injuries sustained by EMS member, David Goodwin, while at Bayshore Hospital (727 North Beers St Holmdel) on June 13, 2019.

Yours faithfully,

William Agar Jr
732-778-2347

Please use deliver records electronically via email to the below UNIQUE address for all replies to this request:
opra+request-21897-89a97d9b@requests.opramachine.com

Is Thomas.Cusick@keansburg-nj.us the wrong address for OPRA requests to Keansburg Borough? If so, please contact us using this form:
https://opramachine.com/change_request/new?body=keansburg_borough

Disclaimer: This message and any reply that you make will be published on the internet. Our privacy and copyright policies:
https://opramachine.com/help/officers

View this OPRA request & responses online:
https://opramachine.com/request/ems_reports

Please note that in some cases publication of requests and responses will be delayed.

If you find this service useful as an OPRA custodian, please ask your web manager to link to us from your organisation's website.

First Report of Injury (FROI) Report Form

Please fax to: 609-631-7736

Rev 1/09

Caller Information:

CALLER'S NAME AND TITLE: Jacob Fera CAPTAIN			PHONE NUMBER: 732-895-6495
WILL YOU BE THE CONTACT PERSON? IF NO, WHO WILL BE CONTACT PERSON?	X YES / NO	CONTACT PERSON'S NAME: Michelle	CONTACT PHONE NUMBER: 732-787-0215

Injury

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

REASON FOR DELAY: N-A

Injured Worker Information

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOC. SEC. NUMBER	DATE OF HIRE
Goodwin, David	7-28-80		5-15-09

ADDRESS (INCLUDE ZIP): 3 Beacon Ter Keansburg NJ 07734

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

HOME PHONE NUMBER:	CELL PHONE NUMBER	# OF DEPENDENTS	EMPLOYMENT STATUS	OCCUPATION/TITLE
		0	Volunteer	EMT

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

Employer

EMPLOYER NAME: Borough of Keansburg

ADDRESS: (Include ZIP) 29 Church St Keansburg, NJ 07734

PHONE NUMBER:	FEDERAL TAX ID:
732-787-0215	

Employee Work Information

TIME EMPLOYEE BEGAN WORK	AM / PM	WHAT ARE HOURS THEIR NORMALLY SCHEDULED SHIFT?	WHAT DATE DID EMPLOYEE NOTIFY SOMEONE OF THEIR INJURY?
1:00		1p-7pm	6-13-19

WHO WAS IT REPORTED TO? (NAME & TITLE)		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	YES / NO	WERE THEY USED?	YES / NO
Jacob Fera CAPTAIN		X		X	

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

NO

Occurrence/Injury

DATE OF INJURY	TIME OF INJURY	AM / PM	DID THE INJURY OCCUR ON THE EMPLOYER'S PREMISE'S?	YES / NO
6-13-19	4:30	PM		NO

LOCATION/DEPARTMENT WHERE INJURY OCCURRED: Bayshore Community Hospital

After off at Bayshore hos Al Dave was
the to the Ambulance a tr. a
ON the floor him to fall to the injured
u t the

WHAT IS THE NATURE OF INJURY AND TO WHAT BODY PART? Fall — Body Part: BACK — Left / Right / X Upper / Lower

WAS THE INJURY FATAL? X YES / NO — DATE OF DEATH: N-A

DID EMPLOYEE SEEK TREATMENT? X YES / NO

WHAT MODE OF TRANSPORTATION TO THE P: Already re

HAS INJURED WORKER RETURNED TO WORK? X YES / NO — IF YES, RETURNED TO WORK DATE:

IF NO, LAST DATE WORKED:

Provider Name Address and Phone No.: ore Community hosp 739-5900

Was Injured Worker hospitalized for more than 24 hours: ☐ YES ☒ NO

Witness

Witness Name and Phone #

Adan O'Sullivan 2-615-8089

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Keansburg Borough
29 Church Street
Keansburg, NJ 07734

CARRIER/ADMINISTRATOR CLAIM NUMBER | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION: NJ | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER: J318890

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE #: 732-787-0215 x21

INDUSTRY CODE: 921120 | EMPLOYER FEIN: 22-3451205

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)
Statewide Insurance Fund
P.O. Box 678
Florham Park, NJ 07932

POLICY PERIOD: 01/01/2019 TO 01/01/2020

CHECK IF APPROPRIATE: [ ] SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
D & H Alternative Risk Solutions
P.O. Box 68
Newton, NJ 078602069

CARRIER FEIN: 22-3301406 | POLICY/SELF-INSURED NUMBER: KEA BR | ADMINISTRATOR FEIN: 22-3445435

AGENT NAME & CODE NUMBER: Brown & Brown Metro BROWNMT

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE): Goodwin, David

ADDRESS (INCL ZIP): 3 Beacon Terrace, Keansburg, NJ 07734

PHONE: 908-433-9665

DATE OF BIRTH: 06/28/1980

SEX: [X] M MALE [ ] F FEMALE [ ] U UNKNOWN

SOCIAL SECURITY NUMBER

MARITAL STATUS: [X] UNMARRIED SINGLE/DIVORCED [ ] M MARRIED [ ] S SEPARATED [ ] K UNKNOWN

OF DEPENDENTS: 0

DATE HIRED: 05/15/2009 | STATE OF HIRE: NJ

OCCUPATION/JOB TITLE: EMT/Volunteer

EMPLOYMENT STATUS: Volunteer

NCCI CLASS CODE: 3560

RATE PER: [ ] DAY [ ] WEEK [ ] MONTH [ ] OTHER:

DAYS WORKED/WEEK: 7

FULL PAY FOR DAY OF INJURY? [ ] YES [X] NO
DID SALARY CONTINUE? [ ] YES [X] NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK: 4:30 [X] AM [ ] PM

DATE OF INJURY/ILLNESS: 06/13/2019

TIME OF OCCURRENCE: 4:30 [X] CANNOT BE DETERMINED [X] AM [ ] PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED: 06/13/2019

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER: Michelle Deroshe 732-787-0215 x212

TYPE OF INJURY/ILLNESS: Strain

PART OF BODY AFFECTED: Multiple Body Parts

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? [ ] YES [X] NO

TYPE OF INJURY/ILLNESS CODE: 52

PART OF BODY AFFECTED CODE: 90

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
727 N Beer St

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
Rug

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
Loading stretcher back in ambulance

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
Loading stretcher back in ambulance

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL
The employee was loading a stretcher back into ambulance when he tripped on rug causing him to fall injuring his lower back, left knee and left arm.

CAUSE OF INJURY CODE: 31

DATE RETURN(ED) TO WORK

IF FATAL GIVE DATE OF DEATH

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? [X] YES [ ] NO

WERE THEY USED? [X] YES [ ] NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Bayshore Community Hospital
727 N Beer St
Holmdel , NJ 07733

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)

INITIAL TREATMENT
0 NO MEDICAL TREATMENT
1 MINOR: BY EMPLOYER
[X] MINOR CLINIC/HOSP
3 EMERGENCY CARE
4 HOSPITALIZED > 24 HOURS
5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)
Aidan O'Sullivan 732-615-8089

DATE ADMINISTRATOR NOTIFIED: 06/14/2019

DATE PREPARED: 06/14/2019

PREPARER'S NAME & TITLE: Jacob Fera , Captain

PHONE NUMBER: 732-895-6495

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION