Student Incidents
Overview for Employees

Aaron Holmberg
Risk Manager

3 Quick Points

- Prevention & Preparation
- Injury Response
- Report

❖ Prevention & Preparation

WATCH

All of us watch for hazards and resolve those hazards before injuries can happen.

REPORT

If you see a hazard, report it. Tell your supervisor or put in a work order. Students should tell their instructors or Campus Police.

BE AWARE

Review the Emergency Guidebook annually so you know what to do if something happens.

INSURANCE

We recommend that all students obtain primary health care insurance. See the student health center website for many options. Students' own insurance will help them be prepared in case something happens.

❖ Injury Response

What's an Employee to Do

- ✓ CALL: 911 **<u>& then</u>** Campus Police (415.239.3000). If they might need an ambulance, then get them one. They can submit the ambulance bill for up to $2,500 to Risk Services @ 33 Gough St. If the student doesn't have primary insurance, then the next page is important.
- ✓ CARE: Let the student know you care. Do not prevent or discourage medical attention even if you don't think it is serious.
- ✓ FIRST AID: First Aid Kits are complete and available throughout the District. Provide first aid if you are prepared and trained to do so.
- ✓ EPISODIC CARE: If not life threatening and on Ocean campus, direct them to Health Center (HC) 100 for first aid. On campus transport is not offered.

Hospital

Give Hospital This

Excess Student Accident Policy

Group: City College of San Francisco

ID Number: SRG 0009153395

This is an excess policy for injuries incurred while participating in a City College of San Francisco supervised / sponsored activity. All other valid and collectible medical insurance policies must be utilized prior to the consideration of this policy.

This plan covers 100% of Usual and Customary costs and as such up-front payments should not be required from CCSF students.

Claims Contact Information: AG Administrators. Attn: Claims. PO Box 979, Valley Forge, PA 19482 PH: (800) 634-8268, Fax (610) 933-4122

Claim Form

Secondary Insurance

If they use the Excess Coverage, then they'll need this form.

Excess coverage claim form ccsf.edu/risk

AG ADMINISTRATORS — SPORTS INSURANCE SPECIALISTS

P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Student Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

College/University City College of San Francisco SRG0009153395

Student's Name ______ FIRST NAME / MIDDLE INITIAL / LAST NAME

Date of Birth ______ Sex: ☐ M ☐ F Cell Phone ______

Email Address ______

School Address ______ STREET / CITY / STATE / ZIP

Home Address ______ STREET / CITY / STATE / ZIP

ACCIDENT INFORMATION

Place of Accident ______ Accident Date ______

Circumstance: ☐ Game ☐ Practice ☐ Conditioning ☐ Other Type of Injury: ☐ Club Sport ☐ Intercollegiate ☐ Intramural ☐ Non-athletic

Body Part Injured ______ Sport if Athletic ______

Nature of Injury — Details of What Happened ______

INSURANCE INFORMATION

Does the claimant have primary insurance? ☐ Yes ☐ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address ______

Policy Number ______ ID# ______

AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

STUDENT SIGNATURE *(Parent or guardian, if participant is a minor)* ______ Date ______

SCHOOL OFFICIAL SIGNATURE ______ Title ______ Date ______

ACC 07/14

Injury Response
Services Available

Episodic Care
Available through the Student Health Services
Our athletes can get this care through our trainers.

Ambulance Coverage
Up to $2,500 to remove the financial consideration from a student when faced with the decision of what to do in the event of a crisis. Send the ambulance bill Risk Services at 33 Gough Street.

Excess Policy
For injuries incurred by students and student athletes while participating in City College of San Francisco supervised/sponsored activities. All other valid and collectible medical insurance policies must be utilized prior to the consideration of this policy.

❖ Report

Report every injury to Risk Services even if the student does not seek treatment. Use form on next slide.

- ❑ If possible, take a picture of the area where the injury occurred and submit that with the report.
- ❑ Gather witness information
- ❑ Speak with injured student (if available) and others about how to prevent this from reoccurring & PUT IN WORK ORDER

Incident Report

To be completed only by City College employee (not the student)

Student's Info →

Witnesses →

Employee/Supervisor Info →

Student Injury/Incident Report

City College of San Francisco

PH: 415-487-2482 • FAX: (415) 241-2344 • www.ccsf.edu/risk
33 Gough Street, San Francisco, CA 94103

CONFIDENTIAL-ATTORNEY/CLIENT WORK PRODUCT PRIVILEGE
Only district employees complete this confidential, internal document. Do not share or copy.
IN CASE OF SERIOUS INJURIES, CALL (415) 487-2482 IMMEDIATELY.

The district employee witnessing the incident or supervising at the time should complete and submit this form within 24 hours. For employee and student-employee injuries, see www.ccsf.edu/workcomp and do not use this form.

DATE OF INJURY

NAME OF INJURED PERSON (LAST, FIRST, M.I.)	AGE	PHONE NUMBER OF THAT PERSON

IS INJURED PERSON A MINOR? ☐ NO ☐ YES	IF MINOR, NAME OF PARENT OR LEGAL GUARDIAN

HOME ADDRESS OF PERSON INJURED (NUMBER, STREET, APARTMENT NUMBER, CITY, STATE, AND ZIP CODE)

WHERE DID INCIDENT OCCUR (DETAILS PLEASE)	TIME ☐ A.M. ☐ P.M.

DESCRIBE HOW INCIDENT OCCURRED (USE FACTS/OBSERVATIONS ONLY; EXCLUDE OPINIONS AND/OR ASSUMPTIONS)	INJURED VIOLATED SCHOOL RULE? ☐ NO ☐ YES

NAME OF PERSON IN CHARGE AT TIME OF INCIDENT	PERSON'S RELATIONSHIP TO COLLEGE	PRESENT AT INCIDENT? ☐ NO ☐ YES

NAME OF WITNESS(ES)	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP

POSSIBLE NATURE OF INJURY
☐ abrasion ☐ fracture ☐ strain/sprain
☐ contusion ☐ cut ☐ dislocation
☐ loss of consciousness ☐ internal ☐ ________

THIS FORM IS A CONFIDENTIAL INCIDENT REPORT AND NOT A DIAGNOSIS OR AN OFFICIAL MEDICAL EVALUATION.

POSSIBLY INJURED BODY PART
☐ head ☐ finger ☐ arm ☐ abdomen
☐ neck ☐ eye ☐ leg ☐ hand
☐ back ☐ chest ☐ face ☐ foot
☐ other: ________

FIRST AID PROCEDURES USED

WHERE DID INJURED GO AFTER ACCIDENT? ☐ Home ☐ Doctor ☐ Hospital ☐ Class ☐ Ambulance	PHONE NUMBER OF FIRST AID PROVIDER

IF INJURED LEFT SITE, WITH WHOM DID THEY LEAVE	PHONE NUMBER OF THAT PERSON	RELATIONSHIP TO INJURED

REMARKS

For your protection California law requires the following to appear on this form. "It is unlawful to: (a) present or cause to be presented any false or fraudulent claim for payment of a loss under a contract of insurance; (b) prepare, make or subscribe any writing with intent to present or use the same, or allow it to be presented or used in support of such claim. Every person who violates any provision of this section is punishable by imprisonment in the State Prison not exceeding 3 years or by fine not exceeding $1,000 or by both."

NAME OF PERSON COMPLETING REPORT	JOB CLASSIFICATION	PHONE NUMBER OF PERSON

ADDRESS OF PERSON COMPLETING REPORT

SIGNATURE	DATE SIGNED	WERE YOU AN EYE WITNESS? ☐ NO ☐ YES

SUBMIT FORM TO AARON HOLMBERG - FAX: (415) 241-2344 - 33 GOUGH STREET, SAN FRANCISCO, CA 94103

Revised 10/16

Recap

- Prevent injuries - www.ccsf.edu/iipp
- Know the emergency plans for your specific location
- Know what to do if a student gets injured
- Report every incident
- Call Risk Services for help