"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION

[To be completed by Employee]

Name (First, Last)	Date of Birth / /	Social Security Number

Address: (Street, City, State, Zip)

Phone Number(s): Home: ( ) Other: ( )

Job Title:	Department:	Shift:

Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:

Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	Worked Until End of Shift ☐YES ☐ NO
Accident was reported to:			

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ **Arm**	☐ **Face**	☐ **Groin**	☐ **Internal Organs**	☐ **Neck**	☐ **Wrist**
☐ **Back**	☐ **Finger**	☐ **Hand**	☐ **Leg**	☐ **Elbow**	☐ **Shoulder**
☐ **Eye**	☐ **Foot/feet**	☐ **Head**	☐ **Knee**	☐ **Stomach**	☐ **Other (describe)**

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.

Employee Signature: **Date:**

Original Signature Required.

SUPERVISOR
ACCIDENT INVESTIGATION REPORT

SUPERVISOR REPORT
[To be completed by the employee's direct supervisor]

Date of Accident / /	Employee's Name (First, Last)	
Supervisor Name:	Department / Location:	

Was this the employee's usual occupation? ☐ Yes ☐ No If No, Describe. Was the employee performing a normal job task? ☐ Yes ☐ No If No, Describe. -- Do you have any reason to believe this employee's injury did *not* occur at work? ☐ Yes ☐ No If Yes, List the Reasons:	Time in occupation. ☐ Less than 1 month ☐ 1 to 5 months ☐ 6 months to 5 years ☐ More than 5 years	Treatment. ☐ First-Aid (In-House) ☐ Emergency Room (Hospital) ☐ Clinic or Doctor's Office --------------------- Name of Clinic or Doctor:

ACCIDENT INVESTIGATION

Accident Sequence

Instructions: Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury and moving back in time, reconstruct the sequence of events that led to the injury.

1. Injury Event
2. Accident Event
3. Preceding Event 1
4. Preceding Event 2
5. Preceding Event 3

Describe the Accident:

Injury Classification

Nature of Injury:

☐ Slip / Fall
☐ Strain
☐ Sprain
☐ Struck Against
☐ Struck By
☐ Puncture
☐ Caught in/or between
☐ Overexertion
☐ Contact with Electrical Current
☐ Burn
☐ Other (describe)
☐ Fall from Elevation
☐ Fall from Same Level

Type of Injury:

☐ Abrasion
☐ Amputation
☐ Burn
☐ Contusion
☐ Crush Injury
☐ Eye - Foreign Body
☐ Fracture
☐ Laceration
☐ Sprain
☐ Puncture
☐ Infection
☐ Illness
☐ Inhalation
☐ Dermatitis
☐ Repetitive Motion
☐ Tendonitis
☐ Other: (describe)

Accident Sketch and/or Photograph(s) (Attach)

Witness(s) Interviews:

(1) Name:
Phone Number:
Statement:

(2) Name:
Phone Number:
Statement:

Casual Factors (Check all factors that contributed to the accident)

- ☐ Unsafe Act
- ☐ Failure to Follow a Standard Operating Procedure
- ☐ Failure to Comply with Direction
- ☐ Hazardous Work Condition
- ☐ Failure to use Personal Protective Equipment
- ☐ Improper use of Equipment and/or Machinery
- ☐ Equipment Malfunction
- ☐ Failure to work at a safe speed/pace
- ☐ Improper body mechanics (i.e. unsafe lifting technique)
- ☐ Unsafe work environment or condition
- ☐ Failure to obey safety policy
- ☐ Inadequate training
- ☐ Horseplay
- ☐ Other:

Comments:

Corrective Actions (corrective actions must be listed for all accidents)

- ☐ Retrain Employee (s)
- ☐ Implement a new or revised job procedure
- ☐ Repair or Modify Equipment or Machinery
- ☐ Use additional Protective Equipment
- ☐ Install Machine Guarding
- ☐ Other. (Please Describe Below)

PROPOSED COMPLETION DATE:

Comments:

Supervisor Signature: Date:

"WITNESS" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]			
Name (First) of witness	(Last)	(Middle initial)	
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:		
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	
Accident was reported to:			

Description of Accident (Describe how the injury occurred, be specific) (include body parts assumed to be injured)

Drawing of Accident:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true. Fraud Notice: Any Individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of the law and may also be subject to criminal and civil penalties.

Witness Signature: **Date:**

Original Signature Required.

EAST COAST RISK MANAGEMENT
7562 State Route 30
North Huntingdon, PA 15642
P–724-864-8745 / F–724-864-9265

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

I hereby authorize and direct you to permit East Coast Risk Management and/or the workers' compensation insurance carrier to inspect, examine, make or obtain copies of all information in connection with my injury or illness. This includes, but is not limited to, all records regarding my medical history, consultation, inpatient and outpatient treatment and diagnostic test results, both films and reports.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.)

______________________________ Patient's Name (Please Print)

____________________ Social Security Number

______________________________ Patient's Signature

____________________ Date

EMPLOYEE ACKNOWLEDGEMENT

UNDER SECTION 306 (f.1) (1) (I) OF THE PA WORKERS' COMPENSATION LAW

I, ______________________________, recognize and agree that my employer has posted a list of at least six (6) healthcare providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO's). I further agree that my employer has provided the name, address, telephone number and area of medical specialty of each designated provider on the list. I also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306 (f.1) (1) (I) of the Pennsylvania Workers' Compensation Act. My rights and duties include, but are not limited to, the following:

I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for ninety (90) days from the date of the first visit to a designated provider. As long as treatment is obtained from a designated provider during the 90-day period, my employer will pay all reasonable medical treatment and supplies related to the injury;

I have the right to switch from one designated health care provider on the list to another during the 90-day period and my employer must pay for this treatment;

If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider;

I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the 90-day period;

I have the right during the 90-day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services;

After the expiration of the 90-day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.

If I treat with a non-designated health care provider after the expiration of the 90-day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for the treatment rendered by the non-designated provider prior to notification; and

If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any heath care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the procedure shall be performed by one or more of the designated health care providers for a period of 90 days from the date of the visit to my health care provider (date of examination of the additional opinion).

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and understand my rights and duties:

______________ Date	______________________________ Employee Signature
______________ Date	______________________________ Witness

PA WORKERS' COMPENSATION INFORMATION

In Pennsylvania, the workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer when self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania (800) 482-2383
Telephone number outside of this Commonwealth (717)772-4447
TTY (800)362-4228 (for hearing and speech impaired only)
www.state.pa.us – PA Keyword: workers comp.

ACKNOWLEDGMENT

I, ____, an

employee of ____________________, hereby certify that I was provided with the above

statement on _____/_____/____date).

____
Employee signature

Laurel Highlands School District – Uniontown (15401)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.

2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.

3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.

4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.

6. If a physician on the list-prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.

7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

PLEASE CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-866-695-3265 FOR ASSISTANCE IN SCHEDULING WITH PHYSICAL / OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITATION

Name	Address	Scheduling	Area of Specialty
MedExpress Urgent Care	289 McClellandtown Rd Uniontown, PA 15401	724-439-3627	Occupational Medicine
The Orthopedic Group	104 Delaware Ave, Suite 100 Uniontown, PA 15401	724-425-0300	Orthopedics
Advanced Orthopaedics	1200 McKean Ave, Suite 106 Charleroi, PA 15022	724-225-8657	Orthopedics
The Orthopedic Group	800 Plaza Dr, Suite 140 Belle Vernon, PA 15012	724-379-5802	Orthopedics
Lementowski & Associates	2 Eastgate Ave, Suite 103 Monessen, PA 15062	724-684-7170	General Surgery
Western Pennsylvania Neurology	100 Peasant Village Lane, Ste 100 Belle Vernon, PA 15012	724-929-7800	Neurosurgery
Laurel Ridge Eyecare	139 W Fayette St Uniontown, PA 15401	724-437-2222	Ophthalmology
Gallo Eye Surgical Assoc.	649 Cherry Tree Lane Uniontown, PA 15401	724-430-2020	Ophthalmology
Garret G Breakiron, DC Uniontown Chiropractic Center	665 Cherry Tree Lane Uniontown, PA 15401	724-437-1910	Chiropractic
Ronald Gouker, DC	15 Metro Plaza Uniontown, PA 15401	724-437-8800	Chiropractic
One Call PT Network	Call Toll Free for Closest Location	1-866-695-3265	Physical Therapy
One Call Chiro Network	Call Toll Free for Closest Location	1-866-695-3265	Chiropractic
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI
Carlisle Medical, Inc.	Call Toll Free for Closest Location	1-800-553-1783	DME
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	DME/Pharmacy
Homelink	Call Toll Free for Closest Location	1-800-571-2943	DME / Supplies