

DIANE WORKMAN
Superintendent

724-775-5464
724-775-7644
FAX: 724-775-7434

Freedom Area School District



Administrative Offices

1702 SCHOOL STREET
FREEDOM, PENNSYLVANIA 15042

ERIN BLUEDORN, CPA
Business Manager
School Board Secretary

www.freedomareaschools.org

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on

_____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit. I understand that I must still complete the Incident Investigation Form and return it along with this form and the signed Acknowledgment and Information pages to the Worker's Compensation Coordinator.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name:

Name

Employee Signature:

Signature

Date

Employer:

Freedom Area School District

Accident Investigation Form



After completing this form, please report the incident by calling 1-800-633-1197 (TTY: 711).

EMPLOYER INFORMATION			
Employer name: FREEDOM AREA SCHOOL DISTRICT			
Street address: 1702 SCHOOL STREET		Phone: 724-775-7644, EXT. 126	
City and state: FREEDOM, PA		ZIP: 15042	County: BEAVER
DETAILS ON INCIDENT			
Date of incident: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S		Time of incident: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Did the incident occur on the employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Location (room number, hallway in front of, etc.): _____	
		Supervisor on duty: _____	
Did employee seek treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		With whom? _____	
Body part(s) injured: _____		Body part(s) previously injured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of incident: _____ <input type="checkbox"/> N/A
Losing time? <input type="checkbox"/> Yes <input type="checkbox"/> No		Last day worked: _____	
How long had employee been working on task? _____		Is this task part of employee's normal duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the employee trained on how to perform the task? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, specify date(s) of training: _____	
Were safeguards or safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		If not, why not? _____	
Were safeguards or safety equipment used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		If not, why not? _____	
Witnesses (attach witness summaries and phone numbers): _____			
<i>Describe the sequence of events and include any objects or substances involved (use additional paper if necessary):</i> _____ _____			
EMPLOYEE INFORMATION			
Last part-time _____		First: _____	Middle: _____
		DOB: _____	
SSN/EEID: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single
Occupation: _____		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual <input type="checkbox"/> Temp	
If part-time, days worked <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> S		Date of hire: _____	
Home street address: _____		Home Phone: _____	
City and state: _____		ZIP: _____	County: _____
Name of other employer: _____		Number of continuous days worked: _____	
Time employee's workday began: _____		<input type="checkbox"/> AM <input type="checkbox"/> PM	
Manager: _____		Department: _____	Work phone: _____

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CAUSES AND ACTION(S) TO PREVENT RECURRENCE (see below and next page)

Immediate causes of incident:

Root causes:

Immediate and future preventive actions:

Preventive action:

Preventive action:

Preventive action:

Person(s) responsible for preventive action:

	Date to be completed:	Date completed:
	Date to be completed:	Date completed:
	Date to be completed:	Date completed:

WORKPARTNERS INFORMATION

Spoke with: Time called: Claim number:

Workpartners contact: Phone number:

Supervisor's signature and phone number: Employee's signature:

HR signature: Date received by HR:

CHECK ALL APPLICABLE EVENTS:

<input type="checkbox"/> Abnormal operation <input type="checkbox"/> Caught between <input type="checkbox"/> Caught in/on <input type="checkbox"/> Equipment failure <input type="checkbox"/> Fall on same level <input type="checkbox"/> Overstress, overpressure, overexertion <input type="checkbox"/> Struck against <input type="checkbox"/> Struck by <input type="checkbox"/> Unexpected action <input type="checkbox"/> Other (describe): 	<p>CONTACT WITH:</p> <input type="checkbox"/> Aggressive consumer/resident/student <input type="checkbox"/> Electricity <input type="checkbox"/> Infectious waste <input type="checkbox"/> Noise <input type="checkbox"/> Radiation <input type="checkbox"/> Temperature extremes <input type="checkbox"/> Toxic/Noxious substances <input type="checkbox"/> Sharp <input type="checkbox"/> Other (describe):
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CHECK ALL APPLICABLE DIRECT CAUSES:

SUBSTANDARD BEHAVIORS

<input type="checkbox"/> Equipment not provided/available <input type="checkbox"/> Failure to check/monitor/analyze <input type="checkbox"/> Failure to communicate/coordinate <input type="checkbox"/> Failure to follow procedure <input type="checkbox"/> Failure to identify hazard/risk <input type="checkbox"/> Failure to properly use PPE <input type="checkbox"/> Failure to warn/secure <input type="checkbox"/> Improper body mechanics <input type="checkbox"/> Improper equipment <input type="checkbox"/> Improper loading/placement 	<input type="checkbox"/> Improper position for task <input type="checkbox"/> Improper PPE <input type="checkbox"/> Improper work technique <input type="checkbox"/> Operating equipment without authority <input type="checkbox"/> Reaching/Bending/Stooping <input type="checkbox"/> Servicing equipment in operation <input type="checkbox"/> Unexpected action <input type="checkbox"/> Unnecessary haste/distraction <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Other (describe):
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SUBSTANDARD CONDITIONS	
<input type="checkbox"/> Defective/Improper tools/equipment <input type="checkbox"/> Equipment failure <input type="checkbox"/> Fire and explosion hazards <input type="checkbox"/> Hazardous substance <input type="checkbox"/> Improper dress/attire <input type="checkbox"/> Improper loading/placement <input type="checkbox"/> Improper maintenance/inspection <input type="checkbox"/> Improper material storage <input type="checkbox"/> Inadequate communications <input type="checkbox"/> Inadequate hazard assessment <input type="checkbox"/> Inadequate information/data	<input type="checkbox"/> Inadequate instructions/procedures <input type="checkbox"/> Inadequate or excessive illumination <input type="checkbox"/> Inadequate preparation/planning/scheduling <input type="checkbox"/> Inadequate support/assistance <input type="checkbox"/> Inadequate/Improper/Missing PPE <input type="checkbox"/> No written procedure/policy <input type="checkbox"/> Poor housekeeping/disorder/slippery conditions <input type="checkbox"/> Poor workstation/process design/layout or congestion <input type="checkbox"/> Safety rule not enforced <input type="checkbox"/> Safety rule violation <input type="checkbox"/> Other (describe):
CHECK ALL APPLICABLE ROOT CAUSES:	
PERSONAL FACTORS	JOB FACTORS
<input type="checkbox"/> Abuse or misuse <input type="checkbox"/> Improper motivation <input type="checkbox"/> Lack of knowledge <input type="checkbox"/> Lack of training/skill <input type="checkbox"/> Mental/Psychological stress <input type="checkbox"/> Physical/Physiological stress <input type="checkbox"/> Fatigue <input type="checkbox"/> Other (describe):	<input type="checkbox"/> Excessive wear/tear <input type="checkbox"/> Inadequate communications <input type="checkbox"/> Inadequate controls <input type="checkbox"/> Inadequate maintenance <input type="checkbox"/> Inadequate supervision <input type="checkbox"/> Inadequate tools/equipment <input type="checkbox"/> Inadequate work standard <input type="checkbox"/> Poor housekeeping <input type="checkbox"/> Other (describe):
AFTER COMPLETING THIS FORM AND CALLING WORKPARTNERS, DELIVER THE FORM TO HR.	

Employer's Name and Address		Date	
City, State, ZIP, County		Emp. Phone	
Injured Worker's Last Name, First Name, Middle Initial		Recur/New Injury Date	
Home Street Address		Home Phone No.	
City, State, ZIP, County		Marital Status	Time Work Began <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Email Address			
Social Security Number		Date of Birth	Date of Hire
Occupation			
<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	If Part-Time, Days Worked <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		Name of Other Employer
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date Reported	Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.
Did incident occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Where:			
Performing regular job at the time of incident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Losing time? <input type="checkbox"/> Yes <input type="checkbox"/> No Last day worked:			
Description of incident (who, what, when, where, how, and why):			
List of body parts injured:			
Prior injuries and with what employer:			
Treatment sought and with whom:			
Name and phone number of witnesses:			
Remarks:			
Reported by:		Date:	Time:

Fraud Statement: Any person who knowingly and with intent to defraud any insurance company, or files an application for insurance or statement of claim containing any material, false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects the person to criminal and civil penalties.

U.S. Steel Tower, 600 Grant Street, 8th Floor, Pittsburgh, PA 15219 •workpartners.com



WORKERS' COMPENSATION INFORMATION

To All Employees:

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 if 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. It is also required to be posted in any areas used for 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:

Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th Fl
Harrisburg, Pennsylvania 17121-0750
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.



**EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER
SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT**

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

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

Employee's Signature Date

Employee's Name (Print) Employee Number

Employer Department

Witness' Signature Date

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

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 physicians 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 contact your Claims Adjuster for any specialty need not listed on this panel.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Heritage Valley BusinessCare - Center	79 Wagner Rd, Ste 100 Monaca, PA 15061	724-773-6464	Occupational Medicine
Worksite Medical	510 Jamison Ave Ellwood City, PA 16117	724-716-6742	Occupational Medicine
MedExpress Urgent Care - Center Township (All Locations - MedExpress.com)	3944 Brodhead Rd, Ste 7B Monaca, PA 15061	724-773-0777	Urgent Care
Heritage Valley Medical Group Surgical Associates	93 Boundary Ln Bridgewater, PA 15009	724-773-6400	General Surgery
*Tri-State Neurosurgical Associates - UPMC - Wexford	12680 Perry Hwy, Ste 201 UPMC Passavant Spine Center Wexford, PA 15090	877-635-5234	Neurosurgery
*Orthopaedic Specialists - UPMC - Cranberry	8000 Cranberry Springs Dr UPMC Lemieux Sports Complex Cranberry Township, PA 16066	877-471-0935	Orthopedics
Tri-State Orthopaedics & Sports Medicine - Seven Fields	400 Northpointe Circle, Ste 101 Seven Fields, PA 16046	724-776-2488	Orthopedics
HVMG Orthopedics	1030 Beaner Hollow Rd Heritage Valley Health System Beaver, PA 15009	724-775-4242	Orthopedics
*UPMC Vision Institute - Wexford	1603 Carmody Ct, Ste 104 Sewickley, PA 15143	412-647-2200	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy