

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

EMPLOYER INFORMATION		计读图表 郑					
Employer name: FREEDOM AREA SCHO	OOL DISTRICT						
Street address: 1702 SCHOOL STREET				Phone: 7	24-775-7644	, EXT. 126	
City and state: FREEDOM, PA				ZIP: 1504	2	County:	BEAVER
DETAILS ON INCIDENT							
Date of incident:	Time of incide	nt:	Did the ir	ncident oc	cur on the e	mployer's	premises?
	☐ AM ☐ PM		☐ Yes 〔	□ No			
			Location ((room num	ber, hallway	in front of,	etc.):
			Superviso	or on duty	:	PHOTOGRA	The second secon
Did employee seek treatment?	☐ No	With whom?			The state of the s		-1)2-1-1
Body part(s) injured:		Body part(s) p		njured?	Date of inci		N/A
Losing time? Yes No		Last day work	ed:				
How long had employee been working on	task?	Is this task par	t of emplo	yee's norr	nal duties?	☐ Yes	☐ No
Was the employee trained on how to period Yes ☐ No	form the task?	If yes, specify	date(s) of	training:			
Were safeguards or safety equipment pr	ovided?	16					1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -
Yes No N/A		If not, why not	?				
Were safeguards or safety equipment us ☐ Yes ☐ No ☐ N/A	ed?	If not, why not	?				
Witnesses (attach witness summaries an	d phone numbe	ers):				1909	
Describe the sequence of events and inc	lude any object.	s or substances	involved ((use additi	onal paper i	f necessar	y):
EMPLOYEE INFORMATION					建制等等		
Last part-time		First:	I	1iddle:	***************************************	DOB:	
SSN/EEID:			☐ Male				Single
Occupation:					t-time 🔲 C	asual 🔲 1	Temp
If part-time, days worked 🔲 M 🔲 T 🔲	W 🔲 T 🔲 F 🗀]s 🔲s	Date of h				
Home street address:				Home Pl	none:		
City and state:		T		ZIP:		County	
Name of other employer:			of continuo	ous days v	vorked:		
Time employee's workday began:	☐ AM ☐ PN	T		and the same of th	T		
Manager:	Manuscript Control of the Control of	Departme	ent:		Work ph	one:	

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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 nur	mber:
Supervisor's signature and phone number:	Employee's signature:	
HR signature:	Date received by HR:	
CHECK ALL APPLICABLE EVENTS:	为是一个人的	
☐ Abnormal operation	CONTACT WITH:	
☐ Caught between	☐ Aggressive consumer/reside	ent/student
☐ Caught in/on	☐ Electricity	
Equipment failure	☐ Infectious waste	
☐ Fall on same level	☐ Noise	
Overstress, overpressure, overexertion	☐ Radiation	
Struck against	☐ Temperature extremes	
☐ Struck by	☐ Toxic/Noxious substances	
☐ Unexpected action	☐ Sharp	
Other (describe):	Other (describe):	
CHECK ALL APPLICABLE DIRECT CAUSES:		· 1000000000000000000000000000000000000
SUBSTANDARD BEHAVIORS		
☐ Equipment not provided/available	☐ Improper position for task	
☐ Failure to check/monitor/analyze	☐ Improper PPE	
☐ Failure to communicate/coordinate	☐ Improper work technique	
☐ Failure to follow procedure	Operating equipment witho	ut authority
☐ Failure to identify hazard/risk	☐ Reaching/Bending/Stooping	
☐ Failure to properly use PPE	Servicing equipment in oper	- -,1
☐ Failure to warn/secure	Unexpected action	
Improper body mechanics	Unnecessary haste/distraction	on
Improper Body Mechanics Improper equipment	Using defective equipment	J.,
Improper equipment Improper loading/placement	Other (describe):	
- mproper rouding/placement	G Julei (describe).	

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SUBSTANDARD CONDITIONS	
☐ Defective/Improper tools/equipment	☐ Inadequate instructions/procedures
☐ Equipment failure	☐ Inadequate or excessive illumination
☐ Fire and explosion hazards	☐ Inadequate preparation/planning/scheduling
☐ Hazardous substance	☐ Inadequate support/assistance
☐ Improper dress/attire	☐ Inadequate/Improper/Missing PPE
☐ Improper loading/placement	☐ No written procedure/policy
☐ Improper maintenance/inspection	Poor housekeeping/disorder/slippery conditions
☐ Improper material storage	Poor workstation/process design/layout or congestion
☐ Inadequate communications	☐ Safety rule not enforced
☐ Inadequate hazard assessment	☐ Safety rule violation
☐ Inadequate information/data	Other (describe):
CHECK ALL APPLICABLE ROOT CAUSES:	
PERSONAL FACTORS	JOB FACTORS
☐ Abuse or misuse	☐ Excessive wear/tear
☐ Improper motivation	☐ Inadequate communications
☐ Lack of knowledge	☐ Inadequate controls
☐ Lack of training/skill	☐ Inadequate maintenance
☐ Mental/Psychological stress	☐ Inadequate supervision
☐ Physical/Physiological stress	☐ Inadequate tools/equipment
☐ Fatigue	☐ Inadequate work standard
Other (describe):	☐ Poor housekeeping
	Other (describe):
	WORKPARTNERS, DELIVER THE FORM TO HR.

analytics | advocacy | **absence** | technology





Report of Injury

Employer's Name and Address			Date
City, State, ZIP, County			Emp. Phone
Injured Worker's Last Name, Firs	t Name, Middle Initial		Recur/New Injury Date
Home Street Address			Home Phone No.
City, State, ZIP, County		Marital Status	Time Work Began
			□ a.m. □ p.m.
Email Address			
Social Security Number		Date of Birth	Date of Hire
Occupation			
☐ Full-time	If Part-Time, Days Worked		Name of Other Employer
☐ Part-time	☐ Mon ☐ Tues ☐ Wed ☐ T	hur 🗆 Fri 🗆 Sat 🗆 Sun	
Hourly Rate	Supervisor		Supervisor Number
Date of Incident	Time ☐ a.m. ☐ p.m.	Date Reported	Time ☐ a.m. ☐ p.m.
Did incident occur on employer's	premises? Yes No	o Where:	
Performing regular job at the tim	ne of incident? ☐ Yes ☐ No		
Losing time? ☐ Yes ☐ No Las	t day worked:		
Description of incident (who, wha	at, when, where, how, and why):		
List of body parts injured:			
Prior injuries and with what empl	oyer:		
Treatment sought and with whon	ո:		
Name and phone number of with	esses:		
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 AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Employee's Full Name	Claim Number
Address	Date of Birth
City, State Zip Code	Telephone Number
Employer	
I hereby authorize the release of my protected health is potentially related to the injury or condition indicated. Benefit Management Services, Inc. or UPMC Health Be its authorized representatives (including attorneys wor practitioners, hospitals, other medical or medically related and insurers, including, but not limited to, those who a Long-Term Disability, Workers' Compensation, Health & Management, and rights under the Americans with Dis Workers' Compensation benefits.	below to WorkPartners, on behalf of UPMC nefits, Inc., as applicable, its successors, or any of rking on its behalf) by all applicable medical ated facilities, pharmacies, claims administrators, administer Group Health, Short-Term Disability, and Wellness, Family Medical Leave, Disease
Description of Injury or Condition:	
Date of Injury or Condition:	

Such disclosure may contain PHI or other information related to my Workers' Compensation medical condition or other condition(s) noted above, including, but not limited to, medical records, patient files, diagnosis, prognosis, progress notes, diagnostic and laboratory tests, treatment plan, prescriptions, wages, or earnings, provided all requests for this information are in writing.

I understand information received pursuant to this authorization may be used by WorkPartners for the investigation and determination of any applicable Workers' Compensation benefits to which I may be entitled. I understand that payment for treatment and benefits may be conditioned upon this authorization; I also understand that my healthcare provider will not condition my treatment based on this authorization. I understand this authorization is valid for the duration of my claim for Workers' Compensation, provided that such duration shall not exceed two years from the date of the signature on the following page.

I understand that WorkPartners may be required to disclose any and all facts related to my injury, illness, or disability to my employer-contracted benefit administrators or insurers (including health benefits provider(s); claims processors; case, disease, or health management companies, and insurers) to determine eligibility for health or disease management programs and for administration and operations of employer benefit plans (including but not limited to Short-Term Disability, Long-Term Disability, Workers' Compensation, coordination of care and quality assurance, health improvement, and utilization review programs).

I certify that all of the information that I have provided is, to the best of my knowledge, true, correct, and complete.

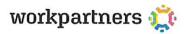


IMPORTANT INFORMATION ABOUT YOUR RIGHTS

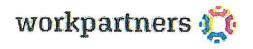
- I have a right to receive a copy of this authorization.
- I may revoke this authorization at any time before its expiration date by notifying WorkPartners in writing (see #2 on the next page), but the revocation will not have any effect on any actions taken before the revocation was received by WorkPartners.
- I understand that any of my PHI received by WorkPartners may be released to others in accordance with the terms of this authorization. Re-disclosure of my PHI by WorkPartners or any other party is not protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please return this completed and signed form by fax to 412-454-8717 or by mail to WorkPartners, PO Box 2971 Pittsburgh, PA 15230.

 1. Type of records to be re ☑ Inpatient ☑ Outpatient ☑ Diagnostic testing ☐ Other: 	leased (check all that apply): ☑ Emerge ☑ Physicia ☑ Physica	15-200 - ▼ 1. 10-00-00 18 - 000 20 97 00-00 97	
Unless you check the behavioral health will be	oox(es) immediately below, no info oe disclosed:	ormation about alcohol/substa	nce abuse, HIV/AIDS or
☐ YES, disclose Inform	ation related to alcohol/substance ation Related To HIV/AIDS oral Health Information	abuse	
2. I may revoke this author	rization by notifying:		
UPMC Insurance Service Attn: Chief Privacy Office 600 Grant Street Pittsburgh, PA 15219 HealthPlanCPO@upmc.e	er		
Signature of Employee OR, if applicable –	Date of Employee's Signature	Employee's Date of Birth or Clair Number	m
Signature of Parent, Legal Guardian or Authorized Representative	Date of Parent, Legal Guardian or Authorized Representative's Signature	Description of Authority to Act f the Employee (i.e., Parent, Legal Guardian or Authorized Representative)	
A copy of this comp	oleted, signed and dated form mu	st be given to the member or o	other signator.
	Official Use Or	nly	
Received	Proce	ssed By	Log #



Provider Information: please use additional sheets of paper as needed Primary Care Physician Name: Address: Telephone Number: Treating Provider Name: Address: Telephone Number: Treating Provider Name: Address: Telephone Number: Diagnostic Testing Provider: Address: Telephone Number: Patient Name (print): Patient Signature: Date of Signature:



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:

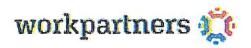
Department of Labor & Industry
Bureau of Workers' Compensation
651 Boas Street 8th FI
Harrisburg, Pennsylvania 17121-0750
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us,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

l,	, employee of
certify that	(employer) I have been provided with, read, and understood the information set forth above 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.

Workpartners Claims Management Services PO Box 2971 Pittsburgh PA 15230



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.

workpartners 🎇

Freedom Area School District - Freedom (15042)

YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS

Send Bills To: PO Box 2971, Pittsburgh, PA 15230 Fax: (412) 454-8717

To Report a Claim Call: 1-800-633-1197 WC Policy:WC100-2033212 Policy Effective Date:07/01/2023

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

 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.

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.

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.

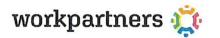
If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-

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>	Address	<u>Scheduling</u>	Area of Specialty
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

accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.





Workers' Compensation Temporary Prescription ID Card Pennsylvania - Commercial

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved workers' compensation prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the Express Scripts Patient Care Contact Center at 800.945.5951.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame al Centro de Contacto para Atención a Clientes de Express Scripts, al 800.945.5951.

To the Pharmacist:

Express Scripts administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of \$150. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance or exposure medications, call Express Scripts at 888.786.9640.

Pharmacy Processing Steps

- Step 1: Enter bin number 003858
- Step 2: Enter processor control WC
- Step 3: Enter the group number as it appears above
- Step 4: Enter the injured worker's nine-digit ID number
- Step 5: Enter the injured worker's first and last name
- Step 6: Enter the injured worker's date of injury

	Express Scripts
ID#:	-
	your temporary ID number; present to the pharmacy at the time is filled. You will receive a new ID number shortly.
Date of In	njury:// MM/DD/YYYY
Group #:	КҮНА
Employee	Date of Birth:/
e e	

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

Employee Information

First	М	Last
	Street Address or PO Box	-

Employer Name





Workers' Compensation Temporary Prescription ID Card Pennsylvania - Commercial

Participating Retail Network Pharmacies

A Plus Pharmacy **AHS Pharmacy** Albright Pharmacy Albion Pharmacy

Alixa Rx

Acme Pharmacy Acme-Sav-On Pharm Anderson Pharmacy

Apex Pharmacy Bath Drug

Bayside Pharmacy Bells Pharmacy

Best Care Pharmacy

Bennetts Valley Pharm **Buchanan Brothers**

Care Options Rx Caresite Pharmacy

Chartwell Pennsylvania Community Pharmacy

Costco **CVS**

Dakes Drug Store Dalton Pharmacy **Deluxe Pharmacy** Diamond Drug Delco Pharmacy Easton Pharmacy

Elmer Pharmacy Eckerd

Falk Pharmacy

Family Rite Pharmacy

Ferri Pharmacy

Fino's Pharmacy

First Class Pharmacy Gerritys Pharmacy

Giant Eagle

Hayden's Pharmacy

Health Direct Hilltop Pharmacy Johnstown Pharmacy Kennie's Pharmacy

Keystone Pharmacy

Laslow's Pharmacy Letrents Pharmacy

Lumberton Drug Martin's Pharmacy Miks Pharmacy

Mill Run Community Oaklane Pharmacy Palmer Pharmacy

Price Chopper Quality Pharmacy

Rite Aid

The Hometown Pharm

Sam's Club

Saubel's Pharmacy Thompson Pharmacy

Shop 'N Save

Target Walgreens Wal-Mart Weamans Weis

Please visit myMatrixx.com and click on 'Pharmacy Locator' to find additional network pharmacies near you.