Accident Investigation Form

workpartners

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: ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S ❑ S	Time of incident:_____ ❑ AM ❑ PM	Did the incident occur on the employer's premises? ❑ Yes ❑ No
		Location (room number, hallway in front of, etc.):
		Supervisor on duty:

Did employee seek treatment? ❑ Yes ❑ No	With whom?	
Body part(s) injured:	Body part(s) previously injured? ❑ Yes ❑ No	Date of incident: ❑ N/A
Losing time? ❑ Yes ❑ No	Last day worked:	
How long had employee been working on task?	Is this task part of employee's normal duties? ❑ Yes ❑ No	
Was the employee trained on how to perform the task? ❑ Yes ❑ No	If yes, specify date(s) of training:	
Were safeguards or safety equipment provided? ❑ Yes ❑ No ❑ N/A	If not, why not?	
Were safeguards or safety equipment used? ❑ Yes ❑ No ❑ N/A	If not, why not?	

Witnesses (attach witness summaries and phone numbers):

Describe the sequence of events and include any objects or substances involved (use additional paper if necessary):

EMPLOYEE INFORMATION

Last part-time	First:	Middle:	DOB:
SSN/EEID:	❑ Male ❑ Female	❑ Married ❑ Single	
Occupation:	❑ Full-time ❑ Part-time ❑ Casual ❑ Temp		
If part-time, days worked ❑ M ❑ T ❑ W ❑ T ❑ F ❑ S ❑ 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: ❑ AM ❑ 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:

- ❑ Abnormal operation
- ❑ Caught between
- ❑ Caught in/on
- ❑ Equipment failure
- ❑ Fall on same level
- ❑ Overstress, overpressure, overexertion
- ❑ Struck against
- ❑ Struck by
- ❑ Unexpected action
- ❑ **Other (describe):**

CONTACT WITH:

- ❑ Aggressive consumer/resident/student
- ❑ Electricity
- ❑ Infectious waste
- ❑ Noise
- ❑ Radiation
- ❑ Temperature extremes
- ❑ Toxic/Noxious substances
- ❑ Sharp
- ❑ **Other (describe):**

CHECK ALL APPLICABLE DIRECT CAUSES:

SUBSTANDARD BEHAVIORS

- ❑ Equipment not provided/available
- ❑ Failure to check/monitor/analyze
- ❑ Failure to communicate/coordinate
- ❑ Failure to follow procedure
- ❑ Failure to identify hazard/risk
- ❑ Failure to properly use PPE
- ❑ Failure to warn/secure
- ❑ Improper body mechanics
- ❑ Improper equipment
- ❑ Improper loading/placement
- ❑ Improper position for task
- ❑ Improper PPE
- ❑ Improper work technique
- ❑ Operating equipment without authority
- ❑ Reaching/Bending/Stooping
- ❑ Servicing equipment in operation
- ❑ Unexpected action
- ❑ Unnecessary haste/distraction
- ❑ Using defective equipment
- ❑ **Other (describe):**

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SUBSTANDARD CONDITIONS

- ❑ Defective/Improper tools/equipment
- ❑ Equipment failure
- ❑ Fire and explosion hazards
- ❑ Hazardous substance
- ❑ Improper dress/attire
- ❑ Improper loading/placement
- ❑ Improper maintenance/inspection
- ❑ Improper material storage
- ❑ Inadequate communications
- ❑ Inadequate hazard assessment
- ❑ Inadequate information/data
- ❑ Inadequate instructions/procedures
- ❑ Inadequate or excessive illumination
- ❑ Inadequate preparation/planning/scheduling
- ❑ Inadequate support/assistance
- ❑ Inadequate/Improper/Missing PPE
- ❑ No written procedure/policy
- ❑ Poor housekeeping/disorder/slippery conditions
- ❑ Poor workstation/process design/layout or congestion
- ❑ Safety rule not enforced
- ❑ Safety rule violation
- ❑ **Other (describe):**

CHECK ALL APPLICABLE ROOT CAUSES:

PERSONAL FACTORS

- ❑ Abuse or misuse
- ❑ Improper motivation
- ❑ Lack of knowledge
- ❑ Lack of training/skill
- ❑ Mental/Psychological stress
- ❑ Physical/Physiological stress
- ❑ Fatigue
- ❑ **Other (describe):**

JOB FACTORS

- ❑ Excessive wear/tear
- ❑ Inadequate communications
- ❑ Inadequate controls
- ❑ Inadequate maintenance
- ❑ Inadequate supervision
- ❑ Inadequate tools/equipment
- ❑ Inadequate work standard
- ❑ Poor housekeeping
- ❑ **Other (describe):**

AFTER COMPLETING THIS FORM AND CALLING WORKPARTNERS, DELIVER THE FORM TO HR.

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U.S. Steel Tower, 600 Grant Street, Pittsburgh, PA 15219

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Report of Injury

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 ☐ a.m. ☐ p.m.
Email Address			
Social Security Number		Date of Birth	Date of Hire
Occupation			
☐ Full-time ☐ Part-time	If Part-Time, Days Worked ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun		Name of Other Employer
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 Where:			
Performing regular job at the time of incident? ☐ Yes ☐ No			
Losing time? ☐ Yes ☐ 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

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UPMCHP WC COMM IMJURY RPRT 17WP2017 (MJA) 10/9/17 PDF

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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 information (PHI) or other information relevant or potentially related to the injury or condition indicated below to WorkPartners, on behalf of UPMC Benefit Management Services, Inc. or UPMC Health Benefits, Inc., as applicable, its successors, or any of its authorized representatives (including attorneys working on its behalf) by all applicable medical practitioners, hospitals, other medical or medically related facilities, pharmacies, claims administrators, and insurers, including, but not limited to, those who administer Group Health, Short-Term Disability, Long-Term Disability, Workers' Compensation, Health and Wellness, Family Medical Leave, Disease Management, and rights under the Americans with Disabilities Act pursuant to my application for Workers' Compensation benefits.

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.

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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 released (check all that apply):

☑ Inpatient
☑ Outpatient
☑ Diagnostic testing
☐ Other: _____
☑ Emergency department
☑ Physician/Office
☑ Physical therapy

Unless you check the box(es) immediately below, no information about alcohol/substance abuse, HIV/AIDS or behavioral health will be disclosed:

☐ **YES**, disclose information related to alcohol/substance abuse
☐ **YES**, disclose Information Related To HIV/AIDS
☐ **YES**, disclose Behavioral Health Information

2. I may revoke this authorization by notifying:

UPMC Insurance Services Division
Attn: Chief Privacy Officer
600 Grant Street
Pittsburgh, PA 15219
HealthPlanCPO@upmc.edu

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Employee	Date of Employee's Signature	Employee's Date of Birth or Claim Number

OR, if applicable –

Signature of Parent, Legal Guardian or Authorized Representative	Date of Parent, Legal Guardian or Authorized Representative's Signature	Description of Authority to Act for the Employee (i.e., Parent, Legal Guardian or Authorized Representative)

A copy of this completed, signed and dated form must be given to the member or other signator.

Official Use Only

Received	Processed By	Log #

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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: _____

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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.

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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.

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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

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.

Name	Address	Scheduling	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.

Panel updated: 3/19/2024

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myMatrixx
An Express Scripts Company

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.

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: KYHA

Employee Date of Birth: _____/_____/_____

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.

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

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

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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
Wegmans
Weis

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

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