Work-Related Incident Report – School Claims Service, LLC

Section One: Employee and Incident Information

SCHOOL DISTRICT NAME (NO ABBREVIATIONS): **Wattsburg Area School District**	SCHOOL DISTRICT ADDRESS: **10782 Wattsburg Road, Erie, PA 16509**	COUNTY: **Erie**

Employee Name (last, first, middle initial):	Home Phone No.:	Gender: M F	Marital Status: M S Dep.

Home address (street, city, state, zip):	County:

Soc. Sec. No.:	Date of Birth:	Date of Incident:	Time of Incident: AM PM	Date Reported:	To Whom it was reported:

Location of Incident (building, room, etc.):	Type of Injury (cut, sprain, etc.):
Injured Body Part:	Cause of Injury (machine, tool, etc.)

Employee's Job Title:	Date of Hire:	Hours Worked per Week:	Time Shift Starts: AM PM

Description of Incident (Please describe in detail what happened):

Name of Supervisor ______________________________

Section Two: Medical Authorization

In, the undersigned, hereby authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authorized representative of School Claims Service, LLC, any and all information which may be requested regarding my physical condition, treatment or disease, and if necessary, to allow them or any physician appointed by them to review any X-rays, regarding my physical condition or treatment.

Employee's Signature: ______________________________ Date: ______________________________

Section Three: For Use of School District's Workers' Compensation Coordinator

TYPE OF CLAIM: ☐ Notice Only (No medical treatment) ☐ Medical Only ☐ Lost time/Last day worked __________

Name of W/C Coordinator: ______________________________ Phone: ________________ Ext.________

Section Four: Medical Treatment

Type of Injury: ____________________ ☐ New ☐ Other (Describe) ______________________________

Treatment/First-Aid: ______________________________

Diagnosis: ______________________________

Disposition: ____________________

- ☐ Return to work without limitations
- ☐ Return to work with noted limitations (describe): ______________________________
- ☐ May return to work on ______________________________
- ☐ Follow-up appointment with: ____________________ on ____________________

Signature of medical/first-aid provider: ______________________________ Date: ______________________________

Address: ______________________________

School Claims Service, LLC
P.O. Box 813
New Cumberland, PA 17070-0813
Tel: (866) 402-6600 Fax: (866) 402-6601

FAX TO SCHOOL CLAIMS SERVICE, LLC WITHIN 24 HOURS OF INJURY

Incident Investigation Report

(To be completed by the supervisor with the employee)

Note: The information provided in this report will be used to promote a safer working environment for all employees by identifying unsafe work practices or conditions. The contents of this report will not be used to criticize or penalize any employees injured on the job.

PLEASE PRINT

Employee name: ________________________________ Date of injury ________________

Employer name: **Wattsburg Area School District**

1. Describe the basic cause(s) of the incident (what *specific factor(s)* caused the incident – what was the employee doing, how was the activity being carried out and what machinery, equipment, tools or objects were involved?):

2. Would you describe this incident being the result of: work practice work environment both
3. Was personal protection equipment or guards provided for this activity? Yes no
4. Was the personal protection equipment or guards being used at the time? Yes no
5. Should personal protection equipment or guards be provided for this activity? Yes no
6. Are there safety rules that apply to this activity? Yes no
7. How could this incident have been prevented?

8. Describe the resulting injuries:

9. Witnesses:

Name	Phone (day)	Phone (evening)

10. Explain in detail what actions could be taken to correct the unsafe act or condition.

11. Who is responsible for implementing the corrective action and when do you anticipate it will be accomplished?

Supervisor signature ________________________________ Date ________________

Incident Investigation Report Form

Workplace Safety and Health Program | Commonwealth of Pennsylvania

A. Injured Employee Data

Employee Name		Working Title	Personnel Number
Work Organization/Location			
Date of accident	Time of Accident ☐ a.m. ☐ p.m.	Claim Number (if known)	
Home Telephone	Work Telephone	Other/Cell Number	
Supervisor's Name		Supervisor's Telephone Number	

B. Accident Description

Instructions: Obtain statements from the injured employee and any witnesses to include what happened, what caused the incident and what were the contributing factors to the incident. To do this, reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. Provide copies of the completed form and all *Incident Statement Forms* to: agency safety coordinator, the field safety coordinator, supervisor and bureau director or field manager.

1. Where did the accident happen and who was involved? Provide a full description of the surroundings of the location and the individual involved.

2. What was happening at the time of the accident and why was it taking place?

3. What were the events leading up to the accident? Describe the sequence in order and when they took place.

4. What exactly caused the injury and how did it happen? What were the mechanics, equipment, or tools involved?

5. Describe the injury or injuries incurred. What body part and what kind of injury? (Indicate if no injury occurred.)

6. If a physical injury was avoided, what could have happened to cause an injury?

C. Accident Findings

After review of all facts, what was the hazardous condition, unsafe work practice, or other causal factors (procedure, equipment, people, and environment) that contributed to the accident/injury?

D. Corrective Action

What is recommended to prevent this type of accident from occurring again?

Actions taken to ensure recommendations are considered:

Signature of Accident Investigator	Date	Time ☐ a.m. ☐ p.m.

E. Distribution Instructions

Original: Agency Safety Coordinator
Copies: Bureau Safety Coordinator (if applicable)

Employee’s Supervisor
Director/Manager of Department or Section
Agency Workers’ Compensation Coordinator (if a workers’ compensation claim was filed)

Maintain one copy in any retrievable format in the site file for a minimum of 3 years. Note: Employee medical and exposure records must be maintained for the duration of employment plus 30.

NOTICE TO EMPLOYEES
Wattsburg Area School District

School Claims Service, LLC Worker's Compensation Division, the claims administrator for the school district's workers' compensation carrier, School Boards Insurance Company of PA, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act.

IN CASE OF A WORK-RELATED INJURY

1. In order to ensure that your medical treatment will be paid for by your employer, or the insurance company, you must select from one of the licensed physicians or practitioners of the healing arts listed.
2. You must continue to visit one of the listed providers for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.

DESIGNATED PHYSICIANS
See Reverse Side

You recognize and agree that your employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). You also acknowledge that you have been presented with this written notice setting forth your rights and duties under Section 306(f.1)(1)(l) of the Pennsylvania Workers' Compensation Act. Your rights and duties include the following:

1. 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 first visit to a designated provider.
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and my treatment related to the injury will be paid by my employer.
3. I have the right to switch from one designated health care provider on list to another during the ninety (90) day period and my employer must pay for this treatment.
4. 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.
5. 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 remainder of the ninety (90) days period.
6. I have the right during the ninety (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.
7. After the expiration of the ninety (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.
8. If I treat with a non-designated health care provider after the expiration of the ninety (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 treatment rendered by the non-designated provider prior to notification; and
9. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health 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 treatment shall be performed by one or more of the designated health care providers for a period of ninety (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'S SIGNATURE

____________________ EMPLOYEE'S NAME (PLEASE PRINT)

____________________ DATE

____________________ WITNESS

March 2015

NOTICE TO EMPLOYEES
Wattsburg Area School District

School Claims Service, LLC Worker's Compensation Division, the claims administrator for the school district's workers' compensation carrier, School Boards Insurance Company of PA, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act. Please read the following notice carefully as it explains important rights and responsibilities.

IN CASE OF A WORK-RELATED INJURY

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 prostheses, including training in their use, as and when needed.
2. In order to ensure that your medical treatment will be paid for your employer or the insurance company, you must select from one of the licensed physicians or practitioners of the healing arts listed.

DESIGNATED PHYSICIANS

MEDICAL PROVIDER	ADDRESS	PHONE	SPECIALTY
Med Express	5039 Peach Street, Erie, PA 16509	814-866-1443	Occupational Health
St. Vincent Occupational Health	1910 Sassafras Street, Suite 200, Erie, PA 16502	814-452-7879	Primary Care
Orthopedic & Sports Medicine of Erie	100 Peach Street, Suite 400 A, Erie, PA 16507	814-454-8287	Orthopedics
Great Lakes Surgeons	104 East 2nd Street, 7th Floor, Erie, PA 16507	814-877-4577	General Surgery
Erie Eye Clinic	128 West 12th, Street, Suite 200, Erie, PA 16501	814-452-2796	Ophthalmology
NovaCare	1717 East 38th Street , Erie, PA 16510	814-899-1023	Therapy
St. Vincent Rehab Solutions	1910 Sassafras Street, Suite 200, Erie, PA 16502	814-452-5231	Therapy
St. Vincent Rehab Solutions	3822 Colonial Avenue, Erie, PA 16506	814-833-7249	Therapy
St. Vincent Rehab Solutions	5165 Imperial Point Parkway, Girard, PA 16417	814-833-7249	Therapy
St. Vincent Rehab Solutions	4950 Buffalo Road , Erie, PA 16510	814-452-5231	Therapy
St. Vincent Rehab Solutions	450 Erie Street , Edinboro, PA 16412	814-833-7249	Therapy
TRAC Rehab	4934 Peach Street, Erie, PA 16509	814-877-5097	Therapy
TRAC Rehab	2101 Nagle Road, Erie, PA 16510	814-877-7078	Therapy
TRAC Rehab	2060 North Pearl Street, North East, PA 16428	814-877-7078	Therapy
TRAC Rehab	991 Route 19, Suite B, Waterford, PA 16441	814-877-5097	Therapy
TRAC Rehab	7287 West Ridge Road, Fairview, PA 16415	814-877-5097	Therapy
TRAC Rehab	1600 Peninsula Drive, Suite 9, Erie, PA 16505	814-877-5097	Therapy
Keystone Rehab	2312 West 15th Street, Erie, PA 16505	814-454-4243	Therapy
Keystone Rehab	4630 Buffalo Road , Erie, PA 16510	814-899-0420	Therapy
Keystone Rehab	4800 Birchdale Drive, Girard, PA 16417	814-774-2035	Therapy
Keystone Rehab	107 Clay Street , North East, PA 16428	814-725-3200	Therapy
Patrick Good, D.C.	14010 Route 8 & 89, Wattsburg, PA 16442	814-739-2775	Chiropractic
Alignetwork	For locations and appointments, please call	1-866-389-0211	Physical Therapy
One Call Medical (OCM)	For locations and appointments, please call	1-800-872-2875	Diagnostic Imaging
Corvel	For prescriptions, please call	1-800-563-8438	Pharmacy

3. You must continue to visit one of the persons listed, if you need treatment, for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.
4. After this ninety day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice. Failure to notify your employer will relieve the employer from liability for payment for services rendered prior to appropriate notice if the services are determined to have been unreasonable or unnecessary.
5. The physician or practitioner of the healing arts who treats you must file a report on a form provided by the Bureau of Workers' Compensation (Form LIPC-9) within ten (10) days of the commencement of treatment and at least once a month as long as treatment continues. A copy of the report must be furnished to you and to your employer. The employer is not liable for payment of any treatment until a report has been filed.
6. If no list is provided above (No. 2) you may go to a licensed physician or practitioner of the healing arts of your choice.
7. If one of the persons listed above refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.
8. If you are faced with a medical emergency, you may secure assistance from a hospital or physician or practitioner of the healing arts of your choice.
9. If the designated provider recommends invasive surgery, you are entitled to receive an additional opinion from any health care provider of your choice. If the additional opinion differs from that of the designated provider, you are entitled to select which course of treatment to follow. However, if you choose to follow the recommendation of your 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 ninety (90) days from the date of the visit to your health care provider (date of examination of the additional opinion).

REMEMBER – IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

March 2015

This sheet to be retained by employee

WATTSBURG AREA SCHOOL DISTRICT
DESIGNATED PHYSICIANS

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Workers' Compensation Division
PO Box 813
New Cumberland, PA 17070
Phone: (866) 402-6600

Patient Name:______________________________
Date of Birth:_____________________________
Claim#: __________________________________

PHYSICAL CAPACITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk: ☐ No restrictions
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
2. In an 8-hour workday, patient can sit: ☐ No restrictions
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during day) ☐ 0-2 ☐ 2-4 ☐ 4-6 ☐ 6-8
3. In an 8-hour workday, patient can drive car/truck: ☐ No restrictions
   (Minutes at one time) ☐ 10-30 ☐ 30-60
   (Hours at one time) ☐ 1-3
4. Patient can lift/carry: ☐ No restrictions or above

Maximum lbs.:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Patient can use hands for repetitive: ☐ No restrictions
   A. Simple Grasping ☐ Yes ☐ No
   B. Pushing & Pulling ☐ Yes ☐ No
   C. Fine manipulation ☐ Yes ☐ No
6. Patient can use feet for repetitive movement as in operating foot controls: ☐ No restrictions
   ☐ Yes ☐ No
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

8. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No restriction
   ☐ Yes – Please explain ______________________________
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No restriction
   ☐ Yes – Please explain ______________________________
10. When will patient be released to return to work:
    Light duty ____________________ Full duty ____________________
11. Will patient be required to use any assistive devices or braces?
    ☐ No restrictions
    ☐ Yes – Please explain ______________________________
    ____
12. Additional comments: ______________________________
    ____

______________________________ ____________
Physician's Signature Date

Thank you for your assistance,

<u>PLEASE FAX TO:</u> SCHOOL CLAIMS SERVICES WORKERS' COMPENSATION DIVISION @ 866-402-6601 <u>AND</u> PROVIDE A COPY TO THE PATIENT