PENN CAMBRIA SCHOOL DISTRICT

WORKERS COMPENSATION PACKET

COVERAGE PROVIDED BY EASTERN ALLIANCE INSURANCE COMPANY

EFFECTIVE JULY 1, 2014

- ☐ Accident Investigation Form – shall be completed by Building Principal, or Supervisor with copy provided to Building Principal.
- ☐ Claim Reporting Worksheet
- ☐ Employee Acknowledgement of Rights & Duties
- ☐ Physician Panel (revised March 2017)

Penn Cambria School District
Accident Investigation Form

NOTE: This form shall be completed by Building Principal or Supervisor, with copy provided to Building Principal.

Employee Name _____ Building _____

Date and time of injury _____/_____/_____
_____:_____ AM or PM (circle one)

Normal starting time:
_____:_____ AM or PM (circle one)

Where did the accident/injury occur? (e.g., room #, room identifier, parking lot, etc.)

_____

_____

_____

Describe the injury sustained: _____

_____

_____

_____

Identify any materials, item or equipment being used at the time of the accident/injury.

_____

Were all safety devices in use at the time of the accident/injury? _____ YES _____ NO
Explain:

_____

_____

_____

How did the accident/injury occur? _____

_____

_____

_____

How can this accident/injury be prevented from happening again?

_____

_____

_____

Provide names and contact information of all witnesses to the accident/injury.

_____

_____

_____

_____ _____/_____/_____

Form completed by (must be Building Principal or Supervisor) Today's Date

Highlighted Sections to be completed by Employee and Building Principal and/or Supervisor.

EASTERN ALLIANCE INSURANCE GROUP CLAIM REPORTING WORKSHEET

24/7 TELECLAIM: 1-800-336-3658 / ONLINE: WWW.EAINS.COM

INSURED INFORMATION

Name and Title of Caller: _____ Phone Number: 814-886-8121

Insured Name: PENN CAMBRIA SCHOOL DISTRICT Policy #: 0000085518

Insured Address: 201 6TH STREET, CRESSON, PA 16630-1363

County: CAMBRIA

Contact Person for Claims: WORKERS COMP COORDINATOR Contact Phone Number: 814-886-8121 x1008

EMPLOYEE INFORMATION

Name: _____ SS#: _____

Home Address: _____ Phone: _____

County: _____

Date of Birth: _____ Gender: _____ Marital Status: _____ # of Dependents: _____

Date of Hire: _____ Hire State: _____ Job Title: _____

Supervisor's Name & Phone Number: _____

Did Employee Received Pay While Off Work Due to Injury?: _____ Employment Status: FT_____ PT_____ Temp_____

ACCIDENT INFORMATION

Date and Time of Accident: _____ Time Shift Begins: _____

Did Accident Occur on Employer's Premises?: _____ Date Reported to Employer: _____

Accident Physical Address: _____ County: _____

Accident Description (Include nature of injury, body part injured, & cause of accident):

_____

_____

_____

Did Accident Result in a Fatality?: _____ Date of Death: _____

Was Time Lost as a Result of the Injury?: _____ Last Date Employee Worked: _____

First Full Day of Work Missed Due to Accident: _____

Has Employee Returned to Work?: _____ Date Returned to Work: _____

Were Safeguards or Safety Equipment Provided?: _____

ACCIDENT INVESTIGATION

Witness Name: _____

Address: _____ Phone: _____

TREATMENT INFORMATION

Did Employee Seek Any Medical Treatment?:

Name of Medical Provider: _____ Is this a Panel Provider?: _____

Address: _____ Phone: _____

Was Employee Hospitalized?: _____ Admit Date: _____

Appendix B

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

Workers' Compensation is designed to provide wage loss benefits and payment for reasonable medical care for one who is injured on the job.

Remember: It is important to tell your employer about your injury immediately.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you must select. You must obtain treatment from one or more of these providers for ninety (90) days from the date of your first visit.

If you have a medical emergency, you may go to the closest hospital, physician or other health care provider of your choice. If follow up treatment is needed, you must then seek treatment from a physician or other health care provider listed on your employer's physician panel list for the first ninety (90) days from the date of your first treatment.

If during the initial 90-day period you wish to change medical providers, you must once again re-visit your employer's panel and select a new physician. If you seek treatment from a non-panel provider within the first ninety (90) days following your first visit, your employer will not have to pay for those services.

In the event invasive surgery is prescribed by a physician or other health care provider on your employer's panel, you are entitled to a second opinion from any other health care provider of your choice. If the opinion differs from the one provided by the panel provider, you may choose which course of treatment to follow. However, the second opinion must state a specific course of treatment. If you choose the treatment offered by the second opinion you must receive that treatment from a panel provider for a period of ninety (90) days from the date of the visit to the provider of the second opinion.

After the initial 90-day period, if additional or continued treatment is needed, you may now choose to go to another physician or health care provider of your choice. Should you decide to change providers, you must notify your employer within five (5) days of your first visit with your new provider. Failure to notify your employer will relieve your employer of the responsibility for the payment of services rendered if such services are determined to have been unreasonable or unnecessary. The non-panel provider must provide an initial report to the employer, within ten (10) days of the first treatment and every thirty (30) days thereafter, as long as the treatment continues.

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

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

☐ ***At Time of Hire*** ☐ ***After an Injury***

Employee Signature_____ Date_____

Witness Signature_____ Date_____

Penn Cambria School District - Cresson, PA 16630
3-24-17
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

MedExpress Urgent Care *(Urgent Care)*	300 East Plank Road, Altoona, PA 16602	814.946.3801
MedExpress Urgent Care *(Urgent Care)*	1221 Scalp Avenue, Johnstown, PA 15904	814.266.1138
Trevor W Yardley, MD *(Orthopedics)*	411 Theatre Drive, Johnstown, PA 15904	814.269.3251
University Orthopedics Center *(Orthopedics)*	3000 Fairway Drive, Altoona, PA 16602	814.942.1166
Valley Orthopedics *(Orthopedics)*	236 Jamesway Road, Ebensburg, PA 15931	814.535.5554
Ophthalmic Associates *(Ophthalmology)*	120 Main Street, Johnstown, PA 15901	814.536.5343
Laurel Eye Clinic *(Ophthalmology)*	176 Vision Drive, Duncansville, PA 16635	814.949.8808
Ciceron L. Opida, MD *(Neurology)*	221 Hospital Dr #1, Tyrone, PA 16686	814.946.5000

PT Network	Call Toll Free for Closest Location	1-866-695-3265	Physical Therapy
Chiro Network	Call Toll Free for Closest Location	1-866-695-3265	Chiropractic
One Call Care-Diagnostics	Call Toll Free for Closest Location	1-800-872-2875	MRI
One Call Care-DME	Call Toll Free for Closest Location	1-800-848-1989	DME
KeyScripts	Call Toll Free for Closest Location	1-866-446-2848	Pharmacy
Homelink	Call Toll Free for Closest Location	1-800-571-2943	DME/Supplies

Additional Providers

UPMC Altoona Cove Surgical Associates *(General Surgery)*	102 Hillcrest Drive, Roaring Spring, PA 16673	814.224.2215
Blair Surgical Associates *(General Surgery)*	2525 9th Avenue #1b, Altoona, PA 16602	814.942.6038
Allegheny Brain and Spine *(Neurosurgery)*	501 Howard Avenue #E1, Altoona, PA 16601	814.946.9150