"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS

EMPLOYEE INFORMATION [To be completed by Employee]			
Name (First, Last)	Date of Birth / /		
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? ☐Yes ☐ No If No, Where?	LOCATION:		
Date of Accident / /	Normal Shift Start Time ☐AM ☐ PM	Time of Accident ☐AM ☐PM	Worked Until End of Shift ☐YES ☐ NO
Accident was reported to:			

Description of Injury (Describe how the injury occurred, be specific)

Part (s) of Body Injured: (check all that apply)

☐ Arm	☐ Face	☐ Groin	☐ Internal Organs	☐ Neck	☐ Wrist
☐ Back	☐ Finger	☐ Hand	☐ Leg	☐ Elbow	☐ Shoulder
☐ Eye	☐ Foot/feet	☐ Head	☐ Knee	☐ Stomach	☐ Other (describe)

Please describe the injured Body Part(s) [i.e. left foot, right thumb]:

I hereby declare that the statements provided in this document are; to the best of my knowledge and belief, complete and true.

Employee Signature: **Date:**
Original Signature Required.

Instructions:

1. Inform your supervisor, Michele Zimmerman and/or Carlie Cole of your injury. Please do not seek treatment from a school nurse. Injuries should be evaluated and treated, if necessary, by a panel physician. An ambulance will be called in the event of an emergency.
2. Complete this form and forward it directly to Michele Zimmerman and/or Carlie Cole.
3. Seek medical advice from a panel physician. Or, if you choose not to treat immediately for your injury, submit this form and the Workers' Compensation Medical Treatment Waiver Form to Michele Zimmerman and/or Carlie Cole.

Hamburg, PA 19526

Workers' Compensation Program: Designated Health Care Providers

The following procedures must be followed in case of work related injury or illness:

A. **Immediately report the injury to your supervisor.**
Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. Supervisors must promptly report injuries to the appropriate personnel office.

B. **Obtain medical care from a provider listed below.**

†Patient First
Occupational Medicine Clinic
2600 Paper Mill Road
Reading, PA 19610
484-220-0051

†WorkCare at St. Joes
Occupational Medicine Clinic
2500 Bernville Road
Reading, PA 19605
610-378-2455

Concentra Medical Center
Urgent Care Clinic
1114 Commons Blvd.
Reading, PA 19605
610-926-0960

†Helmold, Karl W., MD
LVPG Orthopedics and Sports Medicine - Mauch Chunk Street
Orthopedic Surgery
316 Mauch Chunk St
Pottsville, PA 17901
570-621-9380

St. Lukes Care Now - Hamburg
Occupational Medicine Clinic
9 Daves Way
Hamburg, PA 19526
610-628-7201

Tower Health Urgent Care, LLC
Urgent Care Clinic
101 Grand Street
Hamburg, PA 19526
484-750-3890

†Phillips, Jason C., M.D.
Orthopedic Surgery
2211 Quarry Dr
Reading, PA 19609
610-396-5163

Optum
Available at any major pharmacy
PHARMACY
800-393-1398

Heads Up
For the nearest location, please call the toll free number.
DENTIST
855-443-9872

One Call Medical Diagnostics
Requires adjuster approval
DIAGNOSTICS
866-672-3064

One Call Care
Requires adjuster approval
PHYSICAL THERAPY
866-672-3064

Hospital
For Emergency Services, please go to the nearest hospital.
HOSPITAL
(FOR EMERGENCY SERVICES ONLY)

C. **Medical Emergency:**
If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. **If you choose to treat with an out of state provider, you may be subject to balance billing.**

E. **For medical treatment to be paid by your employer:**
1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

***For medical groups, all providers are eligible to render medical services.**

EMPLOYEE ACKNOWLEDGEMENT

UNDER SECTION 306 (f.1) (1) (I) OF THE PA WORKERS' COMPENSATION LAW

I, _____, recognize and agree that my employer has posted a list of at least six (6) healthcare providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO's). I further agree that my employer has provided the name, address, telephone number and area of medical specialty of each designated provider on the list. I also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306 (f.1) (1) (I) of the Pennsylvania Workers' Compensation Act. My rights and duties include, but are not limited to, the following:

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 the first visit to a designated provider. As long as treatment is obtained from a designated provider during the 90-day period, my employer will pay all reasonable medical treatment and supplies related to the injury;

I have the right to switch from one designated health care provider on the list to another during the 90-day period and my employer must pay for this treatment;

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;

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 90-day period;

I have the right during the 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;

After the expiration of the 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.

If I treat with a non-designated health care provider after the expiration of the 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 the treatment rendered by the non-designated provider prior to notification; and

If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any heath 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 procedure shall be performed by one or more of the designated health care providers for a period of 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 Signature

_____ _____

Date Witness

EAST COAST RISK MANAGEMENT
7562 State Route 30
North Huntingdon, PA 15642
P–724-864-8745 / F–724-864-9265

AUTHORIZATION FOR MEDICAL RECORDS AND REPORTS

I hereby authorize and direct you to permit East Coast Risk Management and/or the workers' compensation insurance carrier to inspect, examine, make or obtain copies of all information in connection with my injury or illness. This includes, but is not limited to, all records regarding my medical history, consultation, inpatient and outpatient treatment and diagnostic test results, both films and reports.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.)

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Patient's Signature Date

Hamburg Area School District
Office of Human Resources
701 Windsor Street
Hamburg, PA 19526
Telephone: 610-562-2241 x 1741
Email: carcol@hasdhawks.org
Fax: 610-562-2634

OPTIONAL

Workers' Compensation Medical Treatment Waiver Form

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

Although I am waiving medical treatment at this time, I have submitted the **"Employee Acknowledgement"** and **"Employee Statement of Injury or Illness"** documents with this form, as is required by my employer's Workers' Compensation carrier.

My employer has provided me with their Workers' Compensation panel provider list, and I understand that I have 120 days from the date of the incident to seek medical treatment for work related injuries requiring medical attention. I agree to notify my employer immediately should I choose to seek medical attention on a later date.

I indicate by signing below that I have been informed of my rights and responsibilities relating to workplace injuries and I do not wish to seek medical treatment at this time.

Employee Name: (Full Name) _____

Employee Signature: _____

Signature Date: _____

Witness Name (Full Name): _____

Witness Signature: _____

Signature Date: _____

Workers' Compensation Insurance Company:

Amtrust North America / P.O. Box 94405 Cleveland, OH 44101 / Phone: (888) 239-3909
Policy Effective Date: July 1, 2020 through June 30, 2021

Please report immediately any injury or work-related illness to your direct supervisor and to HR.