

***COUNTY OF  
GREENE***

***WORKERS' COMPENSATION  
INCIDENT REPORT MANUAL  
PROCEDURE***

Updated 7/1/2015

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COUNTY OF GREENE REPORTING PROCEDURE  
WORKERS' COMPENSATION CLAIMS

1. As soon as possible following any accident resulting in employee injury, complete the "Claim Report Form" and forward to East Coast Risk Management immediately.
2. Have employee sign the "Medical Authorization" form if they are going to seek medical treatment.
3. Have employee sign both the Act 57 - "Employee Acknowledgement" form which reminds them that they need to follow the panel of physicians for the first 90 days of treatment, and the "PA Workers' Compensation Information" form explaining the benefits.
4. "Accident Investigation Report"--  
Employee is to complete page 1;  
Supervisor completes pages 2 & 3.
5. REPORT the incident, forwarding all completed forms within 24 hours (or as soon as possible) to:
  - i. County of Greene Human Resources
6. If medical treatment is required, direct your injured worker to your Physician Panel, or for assistance, East Coast Risk Management can arrange an appointment for him/her. (ECRM Phone Numbers: 724-864-8745/ 1-877-864-3311).
7. Only if the injury is a true *EMERGENCY* should an injured worker go to the nearest Emergency Room.
8. East Coast Risk Management will report the claim to your insurance carrier, obtain the claim number and provide it back to you for future reference.
9. East Coast Risk Management will obtain physician's work release & physical capabilities following initial, as well as subsequent doctor visits, ECRM will also facilitate return-to-work and coordinate information among all involved parties -- the physician, the adjuster, and you, the employer.

THE ATTACHED "PANEL OF PHYSICIANS"  
MUST BE POSTED IN CONSPICUOUS  
LOCATIONS FREQUENTED BY ALL  
EMPLOYEES, SUCH AS THE EMPLOYEE  
LUNCH ROOM AND NEAR THE EMPLOYEE  
TIME CLOCK!!!!

# Greene County - Waynesburg

## 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. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. 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.
5. 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.
6. 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.

**FOR ASSISTANCE IN SCHEDULING APPOINTMENTS, PLEASE CALL  
PREMIER COMP TOLL FREE 24 HOURS/7 DAYS A WEEK AT 1-888-594-4001**

Name	Address	Phone	Area of Specialty
Med Express Urgent Care (Multiple Locations)	220 Greene Plaza Waynesburg, PA 15370	724-852-6391	Occupational Medicine
Washington Hospital Occupational Medicine Center	95 Leonard Avenue, Building 1, Suite 401 Washington, PA 15301	724-223-3528	Occupational Medicine
Advanced Orthopaedics and Rehabilitation (Multiple Locations)	112 Walnut Avenue, Suite B Waynesburg, PA 15370	724-627-6948	Orthopedics
Angott & Associates	350 Bonar Avenue Waynesburg, PA 15370	724-627-2788	General Surgery
Regional Eye Associates (Multiple Locations)	226 Elm Drive Waynesburg, PA 15370	724-627-6100	Ophthalmology

**CONVENIENT NETWORK LOCATIONS LISTED BELOW**

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRI's

**Panel Date: 1/15/2015**

I acknowledge receipt of this Notice and understand that I must treat with panel provider(s) for first 90 days.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

FAX FORM TO: 724-743-5945

**\*\* COMPLETE THE "CLAIM REPORT FORM"  
IN ITS ENTIRETY - DO NOT LEAVE ANY  
FIELDS BLANK.**



# CLAIM REPORT FORM

Submitted By  Title  Current Date

Employer Name  Phone Number

Address  Employer FEIN Number

City  State  Zip Code

## EMPLOYEE INFORMATION

First Name  Last Name  SSN

Male  Female Date of Hire

Employee Job Title

Address

Date of Birth

City  State  Zip Code

Marital Status  Single  Married

Pay Type  Hourly  Salaried

Department

Number of Dependents   Full Time  Part-Time

Employee Supervisor  Employee Phone No.

## INJURY INFORMATION

Date of Injury  Time of Injury   AM  PM

Date Employee Reported the Injury

Location of Injury (City, State, Zip)

Time Employee Began Work   AM  PM Work Shift  First  Second  Third

Print Clearly

Description of Accident (be Specific)

Nature of Injury (List all injured body parts)

(Please Specify Left or Right)

Cause of Injury (How the injury or illness occurred)

Type of Medical Treatment Given  No Medical Treatment / Precautionary Report  First-Aid / In-House  
 Occupational Health Center / Panel Physician  Hospital / Emergency Room

Did the employee miss any days of work?  Yes  No

If the employee did miss work, have they returned to work?  Yes  No If yes, enter the first date missed?

If yes, provide the date the employee returned to work?  Full Pay for Day of Injury?  Yes  No

TREATMENT INFORMATION

Name of the facility where initial medical treatment was given

Treating Physician Name  Address

Phone Number  City  State  Zip Code

WITNESS INFORMATION

First Name  Last Name

Address

City  State  Zip Code  Phone Number

INSURANCE INFORMATION

Insurance Carrier Name

Insurance Policy Number

Policy Period: From  To

*Internal Use Only*  
Date Received \_\_\_\_\_  
Time Received \_\_\_\_\_  
Received By \_\_\_\_\_

Claim Reporting Office  
40 Lincoln Way  
North Huntingdon, PA 15642  
Phone: (724)864-8745



ALL EMPLOYEES MUST SIGN THE  
"AUTHORIZATION FOR MEDICAL RECORDS  
AND REPORTS" FORM, AT THE TIME OF  
INJURY. THIS FORM ALLOWS EAST COAST  
RISK MANAGEMENT, SPRING COVE SCHOOL  
DISTRICT AND/OR THEIR WC CARRIER TO  
INTERACT WITH THE PHYSICIAN'S OFFICE.

EAST COAST RISK MANAGEMENT  
40 LINCOLN WAY SUITE 201  
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, County of Greene and/or their 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)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

July 11, 2011 revision

ALL EMPLOYEES MUST SIGN THE  
"EMPLOYEE ACKNOWLEDGEMENT" FORM  
AND THE PA WORKERS' COMPENSATION  
INFORMATION FORM UPON HIRE, EVERY  
TIME THERE IS A CHANGE TO THE PANEL  
OF PHYSICIANS AND AT THE TIME OF EACH  
AND EVERY INJURY.

PLACE SIGNED FORM IN THEIR PERSONNEL  
FILE.

## 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 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 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

## COUNTY OF GREENE

### PA WORKERS' COMPENSATION INFORMATION

In Pennsylvania, 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 when 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, including, without limitation, areas used for the 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 at:

Bureau of Workers' Compensation  
1171 South Cameron Street, Room 103  
Harrisburg, Pennsylvania 17104-2501  
Telephone number within Pennsylvania (800) 482-2383  
Telephone number outside of this Commonwealth (717)772-4447  
TTY (800)362-4228 (for hearing and speech impaired only)  
[www.state.pa.us](http://www.state.pa.us) - PA Keyword: workers comp.

### ACKNOWLEDGMENT

I, \_\_\_\_\_, an

employee of COUNTY OF GREENE hereby certify that I was provided with the above

statement on \_\_\_\_/\_\_\_\_/\_\_\_\_ date).

---

Employee signature

**COMPLETE THE "ACCIDENT  
INVESTIGATION" FORM IN ITS ENTIRETY.**

**PAGE 1 TO BE COMPLETED BY  
INJURED EMPLOYEE**

**PAGES 2/3 TO BE COMPLETED BY  
INJURED EMPLOYEE'S  
SUPERVISOR**

**COUNTY OF GREENE**  
**"EMPLOYEE" - STATEMENT OF INJURY OR ILLNESS**

EMPLOYEE INFORMATION <small>[To be completed by Employee]</small>			
Name (First, Last)		Date of Birth / /	Social Security Number
Address: (Street, City, State, Zip)			
Phone Number(s): Home: ( ) Other: ( )			
Job Title:	Department:	Shift:	
Did the injury occur on the employer premises? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Where?		LOCATION:	
Date of Accident / /	Normal Shift Start Time <input type="checkbox"/> AM <input type="checkbox"/> PM	Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	Worked Until End of Shift <input type="checkbox"/> YES <input type="checkbox"/> NO
Accident was reported to:			
<b>Description of Injury</b> (Describe how the injury occurred, be specific)			
<b>Part (s) of Body Injured:</b> (check all that apply)			
<input type="checkbox"/> Arm	<input type="checkbox"/> Face	<input type="checkbox"/> Groin	<input type="checkbox"/> Internal Organs
<input type="checkbox"/> Back	<input type="checkbox"/> Finger	<input type="checkbox"/> Hand	<input type="checkbox"/> Leg
<input type="checkbox"/> Eye	<input type="checkbox"/> Foot/feet	<input type="checkbox"/> Head	<input type="checkbox"/> Knee
			<input type="checkbox"/> Neck
			<input type="checkbox"/> Elbow
			<input type="checkbox"/> Stomach
			<input type="checkbox"/> Wrist
			<input type="checkbox"/> 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. <b>Fraud Notice:</b> Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.			
<b>Employee Signature:</b> <small>Original Signature Required.</small>		<b>Date:</b>	

## SUPERVISOR ACCIDENT INVESTIGATION REPORT

SUPERVISOR REPORT <small>[To be completed by the employee's direct supervisor]</small>																		
Date of Accident / /	Employee's Name (First, Last)																	
Supervisor Name:		Department / Location:																
<p>Was this the employee's usual occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Describe.</p> <p>Was the employee performing a normal job task? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Describe.</p> <p>----- Do you have any reason to believe this employee's injury did <i>not</i> occur at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, List the Reasons:</p>	<p>Time in occupation.</p> <p><input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1 to 5 months <input type="checkbox"/> 6 months to 5 years <input type="checkbox"/> More than 6 years</p>	<p>Treatment.</p> <p><input type="checkbox"/> First-Aid (In-House) <input type="checkbox"/> Emergency Room (Hospital) <input type="checkbox"/> Clinic or Doctor's Office ----- Name of Clinic or Doctor:</p>																
ACCIDENT INVESTIGATION																		
<p><b>Accident Sequence</b> Instructions: Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury and moving back in time, reconstruct the sequence of events that led to the injury.</p> <p>❶ Injury Event ❷ Accident Event ❸ Preceding Event 1 ❹ Preceding Event 2 ❺ Preceding Event 3</p> <p>-----</p> <p><b>Describe the Accident:</b></p>          																		
Injury Classification																		
<p><b>Nature of Injury:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Slip / Fall</td> <td style="width: 25%;"><input type="checkbox"/> Struck By</td> <td style="width: 25%;"><input type="checkbox"/> Contact with Electrical Current</td> <td style="width: 25%;"><input type="checkbox"/> Fall from Elevation</td> </tr> <tr> <td><input type="checkbox"/> Strain</td> <td><input type="checkbox"/> Puncture</td> <td><input type="checkbox"/> Burn</td> <td><input type="checkbox"/> Fall from Same Level</td> </tr> <tr> <td><input type="checkbox"/> Sprain</td> <td><input type="checkbox"/> Caught In/or between</td> <td><input type="checkbox"/> Other (describe)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Struck Against</td> <td><input type="checkbox"/> Overexertion</td> <td></td> <td></td> </tr> </table>			<input type="checkbox"/> Slip / Fall	<input type="checkbox"/> Struck By	<input type="checkbox"/> Contact with Electrical Current	<input type="checkbox"/> Fall from Elevation	<input type="checkbox"/> Strain	<input type="checkbox"/> Puncture	<input type="checkbox"/> Burn	<input type="checkbox"/> Fall from Same Level	<input type="checkbox"/> Sprain	<input type="checkbox"/> Caught In/or between	<input type="checkbox"/> Other (describe)		<input type="checkbox"/> Struck Against	<input type="checkbox"/> Overexertion		
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<input type="checkbox"/> Sprain	<input type="checkbox"/> Caught In/or between	<input type="checkbox"/> Other (describe)																
<input type="checkbox"/> Struck Against	<input type="checkbox"/> Overexertion																	

**Type of Injury:**

- |                                     |   |                                    |  |  |
|-------------------------------------|---|------------------------------------|--|--|
| <input type="checkbox"/> Abrasion   | <input type="checkbox"/> Crush Injury       | <input type="checkbox"/> Sprain    | <input type="checkbox"/> Inhalation        | <input type="checkbox"/> Other: (describe) |
| <input type="checkbox"/> Amputation | <input type="checkbox"/> Eye - Foreign Body | <input type="checkbox"/> Puncture  | <input type="checkbox"/> Dermatitis        |  |
| <input type="checkbox"/> Burn       | <input type="checkbox"/> Fracture           | <input type="checkbox"/> Infection | <input type="checkbox"/> Repetitive Motion |  |
| <input type="checkbox"/> Contusion  | <input type="checkbox"/> Laceration         | <input type="checkbox"/> Illness   | <input type="checkbox"/> Tendonitis        |  |

**Accident Sketch and/or Photograph(s)** (Attach)

**Witness(s) Interviews:**

**(1) Name:**  
**Phone Number:**  
**Statement:**

**(2) Name:**  
**Phone Number:**  
**Statement:**

**Casual Factors** (Check all factors that contributed to the accident)

- |   |  |
|---|--|
| <input type="checkbox"/> Unsafe Act                                       | <input type="checkbox"/> Failure to work at a safe speed/pace                    |
| <input type="checkbox"/> Failure to Follow a Standard Operating Procedure | <input type="checkbox"/> Improper body mechanics (i.e. unsafe lifting technique) |
| <input type="checkbox"/> Failure to Comply with Direction                 | <input type="checkbox"/> Unsafe work environment or condition                    |
| <input type="checkbox"/> Hazardous Work Condition                         | <input type="checkbox"/> Failure to obey safety policy                           |
| <input type="checkbox"/> Failure to use Personal Protective Equipment     | <input type="checkbox"/> Inadequate training                                     |
| <input type="checkbox"/> Improper use of Equipment and/or Machinery       | <input type="checkbox"/> Horseplay   |
| <input type="checkbox"/> Equipment Malfunction                            | <input type="checkbox"/> Other:  |

Comments:

**Corrective Actions** (corrective actions must be listed for all accidents)

- |   |  |
|---|--|
| <input type="checkbox"/> Retrain Employee (s)                     | <input type="checkbox"/> Use additional Protective Equipment |
| <input type="checkbox"/> Implement a new or revised job procedure | <input type="checkbox"/> Install Machine Guarding            |
| <input type="checkbox"/> Repair or Modify Equipment or Machinery  | <input type="checkbox"/> Other.<br>(Please Describe Below)   |

PROPOSED  
COMPLETION DATE:

Comments:

Supervisor Signature:

Date:

PROVIDED FOR YOU BY:

East Coast Risk Management  
40 Lincoln Way Suite 201  
North Huntingdon, PA 15642  
Phone – 724-864-8745  
Fax – 724-864-9265