CORRY AREA SCHOOL DISTRICT

WORK RELATED INCIDENT REPORT

SCHOOL DISTRICT NAME:	CORRY AREA SCHOOL DISTRICT		#QWC111420
SCHOOL DISTRICT ADDRESS:	540 E PLEASANT ST CORRY PA 16407	**COUNTY:**	ERIE

SECTION I: EMPLOYEE INFORMATION

LAST NAME:		**FIRST NAME:**	**MI:**
HOME ADDRESS:			
CITY:	**STATE:**	**ZIP:**	**COUNTY:**
HOME PHONE:	**GENDER: M F**		**MARITAL STATUS:**
SS #:	**DATE OF BIRTH:**		**DATE OF HIRE:**
JOB TITLE:	**HOURS/WEEK WORKED:**		**TIME SHIFT STARTS:**
SUPERVISOR'S NAME:			

SECTION II: INCIDENT INFORMATION

DATE OF INCIDENT:	**TIME OF INCIDENT:**	**INJURED BODY PART:**
LOCATION OF INCIDENT (Building Name ie., CAIS, CAPS MHS)**:**		
LOCATION ADDRESS:	**TYPE OF INJURY** (cut, sprain, etc.)**:**	
CAUSE OF INJURY (machine, tool, etc.)**:**		
DATE REPORTED:	**TO WHOM REPORTED:**	
WAS THERE A WITNESS? Y N	**NAME(S) OF WITNESS(ES):**	
WERE SAFEGUARDS (SAFETY EQUIPMENT) PROVIDED? Y N		
DESCRIPTION OF INCIDENT (describe in detail what happened):		

SECTION III: TREATMENT

_____ No Medical Treatment

_____ Minor on-site remedies by Employer Medical Staff

_____ Sent Home

_____ Returned to work with Modified Duties

Note Modifications: _____

_____ Medical Treatment Sought

Provide all dates absent from work for medical treatment due to this incident:

_____

_____

EMPLOYEE & SUPERVISOR SIGNATURES ARE REQUIRED ON PAGE 2

SECTION IV: MEDICAL AUTHORIZATION - EMPLOYEE SIGNATURE REQUIRED

I, 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 authroized representative of AmTrust North America, 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 or records regarding my physical condition or treatment.

Employee's Signature: _____ Date: _____

SECTION V: SIGNATURES REQUIRED

I have received the panel of physicans and understand that if I need to seek treatment for this incident, I am to use a physician from that panel.

Employee's Signature: _____ Date: _____

I am aware of and have reviewed this work related incident.

Supervisor's Signature: _____ Date: _____

SECTION VI: MEDICAL TREATMENT BY PANEL PHYSICIAN

If medical treatment is sought, please send a COPY of this report to the Admin office. Take the original form to your appointment with the panel approved physician to complete this section. Then turn in the original to Admin Office.

TYPE OF INJURY: _____

TREATMENT/FIRST AID DIAGNOSIS: _____

DISPOSITION: _____

_____ **Return to work without limitations**

_____ **Return to work with limitations:** Note limitations: _____

_____

RETURN TO WORK ON: _____ **FOLLOW-UP APPOINTMENT ON:** _____

Name of Panel Physician seen (Please Print): _____

Signature of Panel Physician: _____ Date: _____

*****ALL INCIDENTS ARE TO BE REPORTED*****

1. In life threatening situations, immediately seek medical attention, then complete this form.
2. Report incident as soon as possible to your supervisor.
3. Complete this form and turn into your supervisor.
4. Completed forms, signed off by supervisor, are to be sent to the Business Manager in the Admin Office.
5. If seeking medical attention, please be sure to see a panel physician.

CASD Worker's Compensation insurance company is:
AmTrust North America
PO Box 94405
Cleveland OH 44101
Phone: (888) 239-3909 Fax: (678) 258-8399

FOR BUSINESS MANAGER ONLY

Investigation Notes: _____

_____

_____

Investigating Officer's Signature: _____ Date: _____

Business Manager's Signature: _____ Date: _____

Corry Area School District

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. A copy of this list is printed on the reverse side of this form.

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_____

Corry Area School District

PA Workers' Compensation Physician Panel

Policy # QWC 1114200

AmTrust North America Insurance Company

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 ensure that 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 on the following list.

NAME	STREET	CITY, ST, ZIP	PHONE	SPECIALTY
Corry Memorial Hospital	965 Shamrock Lane	Corry, PA 16407	814.665.8288	Family Practice
Medical Group of Corry	315 York Street	Corry, PA 16407	814.664.8686	Family Practice
St Vincent Orthopedic	2315 Myrtle St STE L10	Erie, PA 16502	814.454.2401	Orthopedics
CMH - Griffin, Edward, MD	965 Shamrock Ln	Corry, PA 16407	814.664.4641	Orthopedics
Community Eye Care	110 E Columbus Ave	Corry, PA 16407	814.665.1300	Ophthalmology
Blaney Vision Center	420 N. Center Street	Corry, PA 16407	814.664.8676	Vision Center
Hasbrouck, Allison M., DC	361 Worth Street	Corry, PA 16407	814.664.7041	Chiropractic
Mitchell, Steven D., DC	41 N. Center Street	Corry, PA 16407	814.664/7595	Chiropractic
FYZICAL Physical Therapy	512 East Columbus Ave	Corry, PA 16407	814.664.9346	Physical Therapy
Master's Physical Therapy	407 N. Center Street	Corry, PA 16407	814.663.7878	Physical Therapy

Rx Pharmacy includes: CVS, Rite Aid, Walmart
Plus Tmesys Pharmacy Network – Call 866.599.5426

Additional providers in the AmTrust Network, please visit:

https://www-lv.talispoint.com/amtrust/external/

or call
Rossbacher Insurance Service, Inc.
814.664.7744