KING'S
COLLEGE

WILKES-BARRE, PENNSYLVANIA 18711

MEMO

TO: Injured Employee

FROM: Human Resources

RE: Injury Report

Attached you will find these forms:

- **Workers' compensation telephone reporting worksheet** - must be completed and returned to Human Resources.
- **Workers' compensation employee notification** - sign and return to Human Resources and keep one copy for your records.
- **Listing of panel physicians and Prescription fill form-** for you to keep in the event you need to seek medical attention.

All workplace injuries must be reported even if medical attention was not needed. Please fill out the forms and return to Human Resources and soon as possible. If you have any questions at all, please contact Human Resources.

Thank you

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Name of Employee: _____ Address: _____

DOB: _____ SS#: _____

DOH: _____ Date/Time of Incident: _____

Job Title: _____ Where Incident Occurred (Unit/Room): _____

Reported to Supervisor ☐ Yes ☐ No Date Reported: _____

Name of Supervisor: _____

1. Employee Complaints:

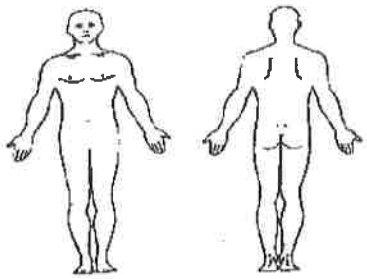
Was there an incident/accident? ☐ Yes ☐ No (If no, go to #2)

If yes, describe how the accident occurred/location of injury: _____

_____

2. Symptom Identification Chart:

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol and include all affected areas.



Numbness	+ + + + + +
Burning	X X X X X
Pins & Needles	0 0 0 0 0

3. Immediate Signs of Distress:

☐ cut ☐ swelling ☐ faint ☐ black/blue discoloration ☐ rash ☐ burn ☐ puncture

☐ redness ☐ itching ☐ coughing ☐ other (Explain: _____)

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4. **Describe Discomfort/Pain:**

☐ immediate onset ☐ delayed onset ☐ sharp ☐ aching ☐ pressure ☐ dull

☐ tightness ☐ running ☐ tingling ☐ numbness ☐ burning ☐ other

5. **Movement Associated with Discomfort:**

☐ bending ☐ reaching ☐ grasping ☐ sitting ☐ twisting ☐ pinching ☐ falling

___ pushing* ___ pulling* ____ lifting* (*approximate weight of object: ___ lbs.)

6. **List all activities that produce discomfort:**

_____ _____

_____ _____

7. **Dynamics of an incident:**
   - Approximate weight of object/client involved ____ lbs.
   - If lifting, object was lifted from _____ height to _____ height from the floor.
   - Was anyone assisting with the task? ☐ Yes ☐ No
   - Were any assistive devices being used? ☐ Yes ☐ No

8. **Check accident cause(s) and comment as necessary. Circle specific factors.**

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Environmental Factors

- ☐ **A. Inadequate Safeguards** – Lack of handling or safety devices, unsafe designing, unguarded machinery.
- ☐ **B. Improper or Defective Equipment** – Poorly maintained equipment; worn, cracked, broken, rough, slippery agencies.
- ☐ **C. Hazards of Location** – Poor layout, congestion, insufficient space for storage, poor lighting, etc.
- ☐ **D. Poor Housekeeping** – Improper piling or placing, clutter; spillage or breakage.
- ☐ **E. Other** - _____

Human Factors

- ☐ **F. Bodily Conditions –** Overweight, emotional upset, fatigue, intoxication, illness, age, poor eyesight, lack of strength, other physical handicaps.
- ☐ **G. Lack of Skill or Knowledge** – Improperly trained, inexperienced, uninformed, unaware, etc.
- ☐ **H. Misconduct** – Chance taking; insufficient interest; unauthorized or unnecessary use of equipment or tools, failure to use or deliberately making safety or control devices ineffective.
- ☐ **I. Improper Apparel** – Improper footwear, lack of personal protective equipment, loose sleeves, torn clothing.
- ☐ **J. Repetitive Motion/Overuse**
- ☐ **H. Other** - _____

9. Patient Handling Incident:

Was this a:
- ☐ One-person transfer
- ☐ Two[person transfer
- ☐ Person lift (enter #)
- ☐ Transfer from bed to chair
- ☐ Transfer from chair to toilet
- ☐ Transfer from floor to chair

Assistive Equipment Used:
- ☐ Gait belt
- ☐ Walking belt
- ☐ Slide board
- ☐ Stretcher
- ☐ Sling
- ☐ Mechanical lift (type)

Patient Condition:
- ☐ Confuxed
- ☐ Fatigued
- ☐ Angry
- ☐ Able to talk
- ☐ Emotional status/behavioral problems
- ☐ Medicated
- ☐ In pain
- ☐ Frail/weak

Patient's Name:_____

10. Did the employee go to: ☐ employee health center ☐ family physician ☐ ER

11. Did the employee lose time? ☐ Yes ☐ No

Supervisor's Signature:_____

King's College - Wilkes Barre

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
MedExpress (Multiple Locations)	677D Kidder Street Wilkes Barre, PA 18702 Location #: 570-825-2046	1-888-594-4001	Occupational Medicine / Urgent Care
Concentra Medical Centers - Wilkes Barre	268 Highland Park Blvd. Wilkes Barre, PA 18702 Location #: 570-822-8831	1-888-594-4001	Occupational Medicine
Orthopedic Specialists	150 Mundy Street, MAC 3 Wilkes Barre, PA 18702 Location #: 570-826-5559	1-888-594-4001	Orthopedics
Sports Medicine Bone & Joint	220 South River Street Plains, PA 18705 Location #: 570-826-1555	1-888-594-4001	Orthopedics
Surgical Specialists - Plains	200 South River Street Plains, PA 18705 Location #: 570-821-1100	1-888-594-4001	General Surgery
Northeastern Eye Institute (Multiple Locations)	679 Kidder Street Wilkes Barre, PA 18702 Location #: 570-825-3491	1-888-594-4001	Ophthalmology
Renaissance Center for Plastic Surgery	1845 Memorial Highway Shavertown, PA 18708 Location #: 570-674-6525	1-888-594-4001	Plastic Surgery
Maurer Chiropractic	104 Wilkes Barre Township Blvd. Wilkes Barre, PA 18702 Location #: 570-822-3212	1-888-594-4001	Chiropractic
Wilkes-Barre General Hospital Wyoming Valley Health Care Systems	575 North River Street Wilkes Barre, PA 18764 Location #: 570-829-8111	1-888-594-4001	Emergency Medicine

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	MRIs

Panel Date: 7/1/18

pennsylvania

Notification to Employees of Their Rights and Duties Under the PA Workers' Compensation Act Section 306 (f.1)(1)(i)

The Pennsylvania Workers' Compensation Act requires that employees be given written notice of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. The text of this section is provided on the next page.

If you are viewing this electronically, your electronic signature will be your acknowledgement that you have been provided with your rights and duties; otherwise, you must acknowledge this with your signature and return it to your employer. You may keep a copy for your records.

Rights and Duties

As an employee of the commonwealth working at a location where a list of designated health care providers has been established and posted, you have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that the commonwealth is not liable for the medical bills incurred. Specific rights and duties are:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.1)(1)(i) and that I understand them to the extent they are explained above.

Employee's Printed Name _____ Employee's Signature _____ Date _____

If you have any questions, ask your human resources office or call the Bureau of Workers' Compensation at 800.482.2383

Revision 5.16.12

pennsylvania

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