Workers' Compensation Packet for Team Members

Team Member Name: _____

Incident Date and Time: _____

As of 01/01/15, all employers must report to OSHA:

- All work-related fatalities within 8 hours.
- All work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours.

Below is a checklist to assist with the injury reporting process.

☐ Take appropriate first aid measures and/or obtain emergency care as needed. Call 911 if necessary.

☐ Notify ***Human Resources Department*** of team member injury immediately at ***610-913-0076***

☐ **Immediately** complete this entire packet and submit to *Workers Comp Carrier*:

- Page 2 – Injured Team Member Form
- Page 3 and 4 – Supervisor Incident Review **(examples of causes and coaching listed below)**:

Examples of Causes	**System** Management, procedures, processes, etc.	Policy/procedure – not in place, not accurate Instruction/skill/training needed Rules enforcement/reinforcement
	Job Equipment, layout, environment, protective equipment, etc.	Floor condition (wet, disrepair, etc.) Equipment malfunction/breakdown/condition Safety devices or equipment not in place, damaged, or not used PPE Condition Leak or spill Unexpected/aggressive resident behavior Care plan inaccurate Bad weather Action of others or 3rd party
	Personal Ability to follow direction, behavior, etc.	Rushing to complete task or hurried approach Fatigue Inattention to task Horseplay Improper sharps handling/disposal Mechanical lift/gait belt use Improper body mechanics Did not adhere to policy/procedure Improper dress/footwear
Example Coaching Approaches (can be completed after WC packet is submitted to Murray Securus): Documented mentoring, work practice observations, attend re-education/re-training session, hazard rounds		

- Page 5 – Witness Statement Form
- Page 6 – Notice of Rights and Duties
- Page 7 – Workers' Compensation Information
- Page 8 – Authorization for Release of Health & Medical Information Form
- Page 9 – Listing of Designated Providers

☐ Submit paperwork to *Workers Comp Carrier*:

- Fax: 717-255-6315
- Email: swengrenovich@murrayins.com

☐ **For an EMERGENCY incident:**

- At a minimum, immediately complete and submit the "Injured Team Member Report Form" to *WC Carrier*. This form may be completed by the Supervisor if the injured team member is unable or unavailable to complete the form immediately following an incident.
- If the "Injured Team Member Report Form" was submitted prior to the completion of the entire packet, complete the remaining forms in the packet as soon as possible following the injury (preferably within 24 hours of the injury).

Injured Team Member Report Form

Complete IMMEDIATELY by INJURED TEAM MEMBER or SUPERVISOR (if team member unable). Fill in as completely as possible.

Berg Construction, LLC *428 California Road, Morgantown, PA 19543*

Team Member's Personal Information – Fill in completely

Last Name:	**First Name:**	**Middle Initial:**	
Home Street Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Cell Phone:**	**Email:**	
Date of Birth:	**Social Security #:**	**Does the team member work for any other company?** ☐ YES ☐ NO ☐ Not Sure	
Sex: ☐ Male ☐ Female	**Marital Status:** ☐ Married ☐ Single		

Team Member's Job Information – Please fill in completely

Job Title:	**Status:** ☐ FT ☐ PT ☐ PRN ☐ Seasonal
Work Location/Department (be specific):	**Supervisor's Name:**

Incident Information – Fill in completely. Use Witness Statement and Team Member Additional Information form if more space needed.

What was the team member doing when the incident occurred?	**Date of Incident:**
	Time of Incident:
	Date notified of injury:
What happened?	**Start time on day of Incident:**
	Was safety equipment provided? ☐ YES ☐ NO ☐ Not Sure
	Was safety equipment used? ☐ YES ☐ NO ☐ Not Sure
What object or substance, if any directly harmed the team member?	**Return to work date:**
	Date of disability:

Witnesses to the injury?

Fatal Injury? ☐ YES ☐ NO **If yes, list the date of death:**

Injury Cause:	**Injury Type (Check all that apply):**			**Body Part Injured:** ☐ Left Side ☐ Right Side ☐ NA			
☐ Strain or Injury By	☐ Sprain/Strain	☐ Dermatitis	☐ Abrasion/Scrape	☐ Abdomen	☐ Eye	☐ Head	☐ Neck
☐ Fall, Slip, or Trip	☐ Cut/laceration	☐ Amputation	☐ Burn (chemical)	☐ Ankle	☐ Fingers	☐ Hip	☐ Shoulder
☐ Struck By	☐ Dislocation	☐ Needlestick	☐ Burn (thermal)	☐ Arm, upper	☐ Foot	☐ Knee	☐ Thigh
☐ Cut, Puncture, Scrape	☐ Bruise	☐ Fracture	☐ Infection	☐ Back	☐ Forearm	☐ Leg	☐ Thumb
☐ Striking Against/Stepping On	☐ Eye injury	☐ Irritation Joint or muscle		☐ Groin	☐ Multiple	☐ Toe(s)	☐ Wrist
☐ Burn/Scald; Heat/Cold Exp.	☐ Puncture	☐ Electrical shock		☐ Chest	☐ Hand		
☐ Caught In, Under, Between	☐ Other:			☐ Elbow	☐ Other		
☐ Other:							

Treatment Information – Fill in completely

Treatment Type:
- ☐ No medical treatment
- ☐ Minor by team member
- ☐ Panel physician
- ☐ Team Member physician
- ☐ Emergency care
- ☐ Clinic/Hospital
- ☐ Hospitalized more than 24 hours

Treatment Taken (describe):		
Name of medical professional providing care:		
Name of facility where treatment was provided:		
Address:		
City:	**State:**	**Zip:**

Additional Information – Fill in as completely as possible

Date of Hire (*required*):	**Hourly Rate of Pay: $**	**Work Phone:**
Is it expected that the team member will miss a full day or shift as a result of the alleged work injury? ☐ YES ☐ NO ☐ Not Sure		
Full pay for the date of injury? ☐ YES ☐ NO	**Has the team member had any prior work injuries?** ☐ YES ☐ NO ☐ Not Sure	
Name of person completing report:	**Title of person completing report:**	**Date completed:**

Supervisor Incident Review

Completed IMMEDIATELY by the SUPERVISOR with the team member involved and at the scene of the incident when possible.

Basic Information – *Complete all sections*					
Supervisor Completing Form:			**Date of Incident:** **Time of Incident:**		**Date of Incident Review:** **Time of Incident Review:**
Team Member Injured:			**Department:**		**Position:**
Building/Area/Location Occurred:			**Working Overtime:** ☐ YES ☐ NO	**Names of Witnesses (attach statements for each witness):**	
Injury Cause:	☐ Strain or Injury By	☐ Struck or Injured By	☐ Striking Against/Stepping On	☐ Caught in Under/Between	
	☐ Fall, Slip, or Trip	☐ Cut, Puncture, Scrape	☐ Burn/Scald; Heat/Cold Exp.	☐ Other:	

Injury Type (check all that apply):						
	☐ Sprain/Strain	☐ Burn (chemical)	☐ Dermatitis	☐ Fracture	☐ Eye injury	☐ Needlestick/Puncture: **(1) Type and brand of device:** **(2) Lot number on device:**
	☐ Cut/Laceration	☐ Burn (thermal)	☐ Puncture	☐ Amputation	☐ Electrical Shock	
	☐ Infection	☐ Irritation joint or muscle	☐ Bruise	☐ Dislocation	☐ Abrasion/Scrape	☐ Other:

Description of Incident – *Have the team member speak freely to describe the incident/do not interrupt/use open-ended?*
Record team member's comments:
What events led up to the incident?
How did the incident occur?
What objects, materials, and/or people were involved in incident? Gather evidence and attach (photos, products, diagrams, etc.)

Incident Cause and Prevention of Future Incidents: ***What needs to be done to prevent another incident involving this Team Member or others?***

****IMMINENT DANGER RISK**.....*If another team member must be placed in this job to take the place of an injured team member, have the necessary corrections been made to prevent immediate injury to the next team member that steps into this job/task?* ☐ YES ☐ NO ☐ Not Applicable

Identify Cause of Incident (see table on page 1 for examples)	**List Specific Hazard(s) Identified**	**Prevention** Address the cause of the incident to prevent another incident.	**Describe Corrective Action**	**Responsible Party**	**Target Completion Date**

Required Signatures Below

Team Member Involved – Signature	Date	Reviewed by Supervisor/Designee – Signature	Date
Reviewed by Safety Comm, Chair – Signature	Date	Reviewed by Human Resources – Signature	Date

Safety Committee/HR Use Only: **This section can be completed after WC packet is submitted**

OSHA Recordable Injury? ☐ **YES** ☐ **NO**

Incident Response Review Date: **By who:**

Prevention Steps Completion Verified Date: **By who:**

Team member have other incidents in past 12 months? ☐ **YES** ☐ **NO**

- If yes, are injury types similar or related? ☐ YES ☐ NO ☐ N/A
- If similar injury types, team member receive coaching? ☐ YES ☐ NO
  Coaching Approach: *(examples on pg 1)*

Team member feedback on prevention of future incident:

Witness Statement and Team Member Additional Information

Use this form to document Witness Statements and/or to provide **additional** information from the Injured Team Member Report Form (does not replace form).

Instructions for Supervisors:

- **Make a copy of this form for each witness**. All witnesses to the incident must complete a form as soon as possible. Request the form is returned to you.
- Use this form in addition to the Injured Team Member Report Form if needed (does not replace form).

Using the check boxes below, indicate the type of information being provided on this form.

☐ **WITNESS STATEMENT** ☐ **TEAM MEMBER – ADDITIONAL INFORMATION**

Witness Information – Please fill in completely	
Witness Last Name:	**Witness Home Phone:**
Witness First Name:	**Witness Cell Phone:**

Incident Information/Additional Information – Please fill in completely		
Team Member Involved in the Incident:	**Date of Incident:**	**Time of Incident:**
Use the space below to either provide additional information or to describe, in your own words, what you witnessed and/or heard. Please provide as much detail as possible. If additional space is needed, continue on the back.		

Required Signature Below	
Witness Signature:	**Date and Time of statement:**

NOTICE OF RIGHTS AND DUTIES

Pennsylvania law requires employers to notify employees of their rights and duties regarding medical services provided under the Workers' Compensation Law (the Act). This notice will provide you a summary of the applicable provisions of the Act:

- Your employer has established a medical panel, which includes at least six designated health care providers, no more than four of whom are coordinated care organizations and no fewer than three of whom are physicians. The employer has not included on this list a physician or health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list.
- You have a 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.
- You have 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 the designated provider during the 90-day period.
- You have the right, during this 90-day period, to switch from one health care provider on the list to another health care provider on the list, and that all treatment shall be paid for by your employer.
- You have the right to seek treatment from a referral provider if a designated provider refers you, and your employer shall pay for treatment rendered by the referral provider.
- You have the right to seek emergency medical treatment from any provider, but subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
- You have the right to seek treatment or medical consultation from a nondesignated provider during the 90-day period, but these services shall be at your expense for the applicable 90 days.
- You have a right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by your employer, if it is reasonable and necessary.
- After ninety (90) days from the date of first treatment, you have a duty to notify your employer of treatment by a nondesignated provider within 5 days of the first visit to that provider. Your employer may not be required to pay for treatment rendered by the nondesignated provider prior to receiving this notification. However, your employer shall pay for these services once notified, unless the treatment is found unreasonable by a utilization review organization.
- You have the right to seek an additional opinion from any health care provider of you choice when a designated provider prescribes invasive surgery for you. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, you shall determine which course of treatment to follow. If you opt to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on your employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

ACKNOWLEDGEMENT OF RIGHTS AND DUTIES

I hereby acknowledge that my employer has provided me with a copy of this "Notice of Rights and Duties". I have been informed of and I understand my rights and duties pertaining to medical treatment for work related injuries thereunder. This notice was presented to me at (check one):

☐ Time of hire or orientation

☐ Immediately after the injury, or as soon thereafter as possible

☐ Other: _____

_____ _____

Team Member Signature Date

_____ _____

Employer Representative Date

Workers' Compensation Information

(1) 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.

(2) 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.

(3) You should report immediately any injury or work-related illness to your employer.

(4) Your benefits could be delayed or denied if you do not notify your employer immediately.

(5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

(6) 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, PA Keyword:
workers comp.

I hereby acknowledge receipt of the "Workers' Compensation Information" form.

_____ _____

Team Member Signature Dated: at time of injury

_____ _____

Employer Witness: Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I hereby authorize all healthcare providers to use and disclose my Protected Health Information (PHI) as described in this authorization. A photocopy of this Authorization is as valid as the original.

PATIENT IDENTIFICATION INFORMATION

Claim Number:

Patient's Full Name:

Last First Middle

Address:

Social Security Number: Date of Birth:

Name and address of recipient: **Penn National Insurance**
P.O. Box 2361
Harrisburg, PA 17105-2361

RELEASE

The purpose of use or disclosure of patient information is for my workers' compensation claim.

I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: hospital and emergency operational logs; outpatient records; medical reports; clinical notes; nurses' notes; physical therapy records; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; bills for services; payments received; and any other relevant and material information in the health care provider's possession. This Authorization also includes, if applicable, drugs/alcohol, psychiatric/psychological services and social work disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or ARC reports. This authorization includes the release of documents in the possession of the healthcare provider whether or not created in your office or by another healthcare provider.

I also agree that any and all of my health care providers may discuss the details of my medical information with the representatives of the above named recipient. However, the health care provider will not condition treatment on the completion of the authorization.

CONDITIONS

I understand that information released in response to this authorization may be used or disclosed to administer, determine and/or litigate my claim. Patient information may be re-disclosed to Murray Securus, their agents and representatives; authorized information is subject to disclosure to other parties, and any other person, firm or entity that releases materials pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that this authorization is valid until my case has been closed and for up to one year from the date of closure. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing to Murray Securus. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I have read this Authorization and understand that I can retain a copy.

Patient, the patient's personal representative or patient's guardian (if the patient is a minor or incapacitated adult)

Date

Printed name, address, phone number of guardian

Description of Authority to Act for Patient:

NOTICE: 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 purposes 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.

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