DIANE WORKMAN
Superintendent

724-775-5464
724-775-7644
FAX: 724-775-7434

Freedom Area School District

Administrative Offices

ERIN BLUEDORN, CPA
Business Manager
School Board Secretary

www.freedomareaschools.org

1702 SCHOOL STREET
FREEDOM, PENNSYLVANIA 15042

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

_____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit. I understand that I must still complete the Incident Investigation Form and return it along with this form and the signed Acknowledgment and Information pages to the Worker's Compensation Coordinator.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name:

_____
Name

Employee Signature:

_____ _____
Signature Date

Employer:

Freedom Area School District

Incident investigation form

Incident details	
Name of person involved in the incident:	Date of incident:
Location of incident:	
Incident investigation team:	

What task was being performed at the time of the incident?

What happened? (e.g. 'employee tripped over box' or 'forklift hit wall')

What factors contributed to the incident?

Environment:		**Equipment/materials:**	
☐ Noise	☐ Layout / design	☐ Wrong equipment for the job	☐ Equipment failure
☐ Lighting	☐ Dust / fume	☐ Inadequate maintenance	☐ Material / equipment too heavy / awkward
☐ Vibration	☐ Slip / trip hazard	☐ Inadequate guarding	☐ Inadequate training provided
☐ Damaged / unstable floor	☐ Other	☐ Other	
Work systems:		**People:**	
☐ Hazard not identified	☐ No / inadequate risk assessment conducted	☐ Procedure not followed / no procedure exists	☐ Drugs / alcohol
☐ No / inadequate safe work procedure	☐ No / inadequate controls implemented	☐ Fatigue	☐ Time / production pressures
☐ Hazard not reported	☐ Inadequate training / supervision	☐ Change of routine	☐ Distraction / personal issues / stress
☐ Other		☐ Lack of communication	☐ Other

Corrective actions:

Contributing factor (from above list)	What are we going to do to fix the problem?	Who	When	Completion date

Issue fixed?

Name	Signature	Date
Person involved in incident:		
Manager:		

Incident investigation process guide

1. Establish the facts of the incident, including:
   - What happened?
   - When and where did it happen?
   - What task was being done?
   - Who was involved?
   - Were there any witnesses?

2. Gather all necessary background information, for example:
   - maintenance records
   - safe work procedures
   - instructions manuals
   - training records.

3. Consider all the potential contributing factors:
   - Environment: *Did environmental conditions (e.g. light, noise, floor surfaces) contribute to the incident?*
   - Equipment /materials: *Did anything about the equipment, materials, tools etc (e.g. equipment failures, missing guards) contribute to the incident?*
   - Work systems: *Was there something about the system that contributed (e.g. hazard not identified, known hazard not addressed)?*
   - People: *Was there something the workers, supervisors or contractors did that contributed to the incident (e.g. poor communication, being tired or rushing to finish on time)?*

4. Determine the primary cause/s of the incident, that is, those which if they hadn't occurred then the incident wouldn't have occurred. Ask yourself *"Would the incident have happened if....?"*

5. Identify the root cause / system failures that underlie the primary cause/s and contributing factors.

   One simple technique for identifying the root cause is the 'Five Whys'. This technique involves asking yourself 'Why did this happen?' and continuing to ask 'Why' for each response until you reach a conclusion that does not generate another 'why' and the underlying cause becomes apparent.

6. The final and most import step in any investigation is to take action to fix all the factors that contributed to the incident, starting with the primary cause/s and working through each of the contributing and underlying causes.

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WORKERS' COMPENSATION INFORMATION

To All Employees:

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 if 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. It is also required to be posted in any areas used for 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:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)
certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

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EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature _____ Date _____

Employee's Name (Print) _____ Employee Number N/A

Employer Freedom Area SD Department _____

Witness' Signature _____ Date _____

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Freedom Area School District - Freedom (15042)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy:WC100-2033212
Policy Effective Date:07/01/2022

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.
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 physicians 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 listed below.

Name	Address	Scheduling	Area of Specialty
Heritage Valley BusinessCare - Center	79 Wagner Rd, Ste 100 Monaca, PA 15061	724-773-6464	Occupational Medicine
Worksite Medical	510 Jamison Ave Ellwood City, PA 16117	724-716-6742	Occupational Medicine
MedExpress Urgent Care - Center Township All Locations - medexpress.com	3944 Brodhead Rd, Ste 7B Monaca, PA 15061	724-773-0777	Urgent Care
Heritage Valley Medical Group Surgical Associates	93 Boundary Ln Beaver, PA 15009	724-773-6400	General Surgery
*Tri-State Neurosurgical Associates - UPMC - Wexford	12680 Perry Hwy, Ste 201 UPMC Passavant Spine Center Wexford, PA 15090	877-635-5234	Neurosurgery
Orthopaedic Specialists - UPMC - Cranberry	8000 Cranberry Springs Dr UPMC Lemieux Sports Complex Cranberry Township, PA 16066	877-471-0935	Orthopedics
Tri-State Orthopaedics & Sports Medicine - Seven Fields	400 Northpointe Circle, Ste 101 Seven Fields, PA 16046	724-776-2488	Orthopedics
HVMG Orthopedics	1030 Beaner Hollow Rd Heritage Valley Health System Beaver, PA 15009	724-775-4242	Orthopedics
Sewickley Eye Group - Beaver Valley	95 A Golfview Dr Monaca, PA 15061	724-770-9000	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.

Panel updated: 8/11/2022

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Policy Effective Date:07/01/2022

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Name	Address	Scheduling	Area of Specialty
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

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