NOTICE TO EMPLOYEES

GENERAL McLANE SCHOOL DISTRICT

C.M. Regent, the claims administrator for the school district's workers' compensation, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act.

IN CASE OF WORK-RELATED INJURY

1. In order to ensure that your medical treatment will be paid for by your employer, or the insurance company, you must select from one of the following licensed physicians or practitioners of the healing arts.
2. You must continue to visit one of the listed providers for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.

DESIGNATED PHYSICIANS

MEDICAL PROVIDER	***ADDRESS***	***PHONE***	***SPECIALTY***
UPMC Urgent Care Erie – West	7200 Peach St. Erie, PA 16509	814-860-3301	Urgent Care
St. Vincent Occupational Health Clinic (Now located in Yorktown Centre)	2501 W 12th St. Suite C Erie, PA 16505	814-452-7879	Occupational Health
St. Vincent Occupational Health Clinic	4950 Buffalo Rd. Erie, PA 16510	814-898-2576	Occupational Health
Med Express – Millcreek	5039 Peach St. Erie, PA 16509	814-866-1443	Urgent Care
Med Express – Meadville	18471 Smock Highway #107 Meadville, PA 16335	814-333-3627	Urgent Care
UPMC Urgent Care Erie –West	2861 W. 26th Street Erie, PA 16506	814-835-6695	Urgent Care
St. Vincent Urgent Care West	4247 W Ridge Road Erie, PA 16506	814-835-2580	Urgent Care
James Spaulding, DC	106 Waterford St. Edinboro, PA 16412	814-734-3422	Chiropractor
Orthopedic Associates of Meadville	11277 Vernon Pl. Suite 200 Meadville, PA 16335	814-724-1252	Orthopedics
Orthopedic & Sports Medicine of Erie	100 Peach Street – Suite 400 Erie, PA 16507	814-454-8287	Orthopedics
Howard Levin, M.D.	2640 Zuck Road Erie, PA 16506	814-838-9555	Ophthalmologists
John Amy, D.C.	12650 Edinboro Road Edinboro, PA 16412	814-734-4541	Chiropractic
One Call Care Management (OCCM)	For locations and appointments, please call	800-453-0574	PT, DME, Diagnostic Studies, Home Health
Corvel	For prescriptions, please call	800-563-8438	Pharmacy

You recognize and agree that your employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). You also acknowledge that you have presented with this written notice setting forth your rights and duties under Section 306(f.1) (1) (I) of the Pennsylvania Workers' Compensation Act. Your rights and duties include the following:

1. 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 first visit to a designated provider.
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
4. 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.
5. 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 remainder of the ninety (90) day period.
6. I have the right during the ninety (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.
7. After the expiration of the ninety (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.
8. If I treat with a non-designated health care provider after the expiration of the ninety (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 treatment rendered by the non-designated provider prior to notification; and
9. 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 treatment shall be performed by one or more of the designated health care providers for a period of ninety (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'S SIGNATURE
	_______________________
	EMPLOYEE'S NAME (PLEASE PRINT)
_______________________	_______________________
DATE	WITNESS

<u>REMEMBER – IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY</u>

Work-Related Incident Report

(To be conducted by the supervisor with the employee)

Note: This form is used to report employee and incident information to the insurance company. Please make sure all sections are filled out completely and accurately to ensure prompt filing with the insurance company.

Section One: Employee Information

Last 4 of Social Security #: __________ DOB: ______________ Employee Name: ______________________________

Home Address: ____ County: ______________

Home Phone #: ________________ Gender: M ☐ F☐ Employee's Job Title: ______________________

Department: ________________ Primary Job Location: ______________________ Date of Hire: __________

Hours Worked Per Week: ________ Start Time: __________ Supervisor's Name: ______________________

Section Two: Incident Information

Date & Time of Incident: ________________ Date Reported: __________ To Whom Reported: ______________

Location of Incident (building, room, etc): ____________________ Type of Injury (cut, sprain, etc): ______________

Injured Body Part: ____________________ Cause of Injury (machine, tool, liquid, etc): ______________________

Description of Incident (please describe in detail what happened):

Section Three: No Medical Treatment

☐ Returned to Work	☐ Returned to Work – Onsite 1st Aid Provided	☐ Sent Home

Section Four: Sent Out For Medical Treatment

Treatment: ____

Diagnosis: ____

Disposition:
- ☐ Return to work without limitations
- ☐ Return to work with limitations (describe):

  ____
- ☐ May return to work on: ____
- ☐ Follow-up appointment with: ______________________________ on ______________

Medical Facility Name/Address: ____

Section Five: Signatures

Employee's Signature: ____________________________________ Date: ______________

Supervisor's Signature: ____________________________________ Date: ______________

General McLane School District

Internal Incident Investigation Report

(To be conducted by the supervisor with the employee)

Note: The information provided in this report will be reviewed at the monthly safety committee meeting and used to promote a safer working environment for all employees by identifying unsafe work practices or conditions. The contents of this report will not be used to criticize or penalize any employees injured on the job.

Employee Name ______________________________ Date of Injury ____________________

1. Describe the basic cause(s) of the incident (what *specific factor(s)* caused the incident – what was the employee doing, how was the activity being carried out and what machinery, equipment, tools or objects were involved):

2. Would you describe this incident being the result of:

   ☐ work practice ☐ work environment ☐ both ☐ other ____________________

3. Was personal protection equipment or guards provided for this activity? ☐ yes ☐ no ☐ n/a
4. Was the personal protection equipment or guards being used at the time? ☐ yes ☐ no ☐ n/a
5. Should personal protection equipment or guards be provided for this activity? ☐ yes ☐ no
6. Are there safety rules that apply to this activity? ☐ yes ☐ no
7. How could this incident have been prevented?

8. Describe the resulting injuries.

9. Witnesses:

Name	Phone (day)	Phone (evening)

10. Explain in detail what actions could be taken to correct the unsafe act or condition.

11. Who is responsible for implementing the corrective action and when do you anticipate it will be accomplished?

Supervisor's signature ______________________________ **Date** ____________________