Philadelphia College of Osteopathic Medicine

EMPLOYEE INCIDENT REPORT

EMPLOYEE INFORMATION – PLEASE TYPE OR PRINT (TO BE COMPLETED BY EMPLOYEE)

NAME (LAST, FIRST, MIDDLE INITIAL)

SOCIAL SECURITY	MARITAL STATUS	BIRTH DATE	HOME PHONE	# OF DEPENDENTS UNDER 18

REGULAR WORK SCHEDULE TIME	JOB TITLE	DATE OF HIRE

CURRENT ADDRESS (STREET, CITY, STATE)

INCIDENT INFORMATION

ADDRESS OF INCIDENT (STREET, CITY, STATE)	DATE OF INCIDENT	TIME OF INCIDENT

DESCRIBE HOW THE INCIDENT OCCURRED AND ANY RESULTING INJURY

LIST ANY EQUIPMENT, MACHINERY, OR CONTRIBUTING FACTORS TO THE INCIDENT (PLEASE ONLY INCLUDE FACTUAL INFORMATION)

IDENTIFY PARTS OF BODY INJURED:

LIST OTHER EMPLOYEES INVOLVED OR WITNESSES

I AGREE THAT THE ABOVE IS TRUE, CORRECT, AND COMPLETE

EMPLOYEE'S SIGNATURE______________________________________ DATE_____________ TELEPHONE #_____________________

SUPERVISOR'S REPORT

SUPERVISORS NAME	DATE INCIDENT REPORTED	DEPARTMENT

DID YOU WITNESS THE INCIDENT?
NO YES DESCRIBE/COMMENTS:

WHAT WAS THE EMPLOYEE DOING WHEN INJURED? (BE SPECIFIC, IDENTIFY TOOLS OR MATERIALS INVOLVED AND EXPLAIN HOW THEY WERE BEING USED)

HOW DID THE INJURY OCCUR? (DESCRIBE FULLY THE EVENTS RESULTING IN THE INJURY/ILLNESS. NAME ANY OBJECTS OR SUBSTANCES INVOLVED)

DID THE INJURY RESULT FROM MECHANICAL DEFECT?
NO YES DESCRIBE/COMMENTS:

DID THE INJURY RESULT FROM AN UNSAFE ACT?
NO YES DESCRIBE/COMMENTS:

WAS ACTION TAKEN TO PREVENT SIMILAR INCIDENTS?
NO YES DESCRIBE/COMMENTS:

EMPLOYEE WAS REFERRED TO:	EMERGENCY ROOM	REFUSED TREATMENT

SUPERVISOR'S SIGNATURE	DATE	PHONE

MEDICAL INFORMATION

EXAMINING PHYSICIAN:	DATE

DIAGNOSIS:

COMPLETED FORMS MUST BE SIGNED AND RETURNED TO RISK MANAGEMENT WITHIN 24 HOURS

MEDICAL RECORDS RELEASE AUTHORIZATION

CLAIM NUMBER: ________________

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits with respect to this claim, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim and the payment of benefits or the administration of the insurance program under which the claim has been made. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to The PMA Insurance Group, P.O. Box 25250, Lehigh Valley, Pennsylvania, 18002, otherwise this authorization will continue to be valid. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing.

Authorization to Release Medical Information

I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to any of the PMA Insurance Group of Companies (including the PMA Insurance Company and PMA Management Corporation), and their subsidiaries, affiliates, representatives and agents (collectively, PMA), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems.

I also authorize the Social Security Administration to release to PMA information concerning entitlement dates and benefit amounts for myself and my dependents.

I further authorize PMA to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that PMA considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand the information released to PMA as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for three years after the claim has been closed by PMA. A copy of this authorization is to be considered as valid as the original.

Employee Signature ______________________ Date ________________________________

Employee Name ____

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

Workers' Compensation is designed to provide wage loss benefits and reimbursement for reasonable medical care for one who is injured on the job. Your employer shall provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

Your employer, in compliance with the Workers' Compensation Act, has posted a list of at least six (6) medical providers from which you are to select. You are to obtain treatment from one of the providers of your choice for ninety (90) days from the date of your first visit.

If you are faced with an immediate medical emergency, you may secure assistance from 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 do not seek treatment from a provider on the panel list for the initial 90 days following your first visit, your employer will not have to pay for the services rendered.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide by same for 90 days.

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 the services rendered if such services are determined to have been unreasonable or unnecessary.

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.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

Employee signature ____________________ Date ______________

WORKER'S COMPENSATION EMPLOYEE NOTIFICATION

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.

NOTICE TO EMPLOYEES

Your employer has provided for the payment of benefits under the Workers' Compensation Act of this State

IN CASE OF WORK-RELATED INJURY

- 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 prostheses, including training in their use.
- In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must immediately advise your supervisor of your injury and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

DESIGNATED PHYSICIANS
(Including address, telephone number, and area of medical specialty)

CLINICS

WORKNET Occupational Medicine
5800 Ridge Avenue, Suite 234
Philadelphia, PA 19128
215-487-4540
(Hours: 8:00a.m. - 4:30p.m. (M-F)

PHYSCIANS/SPECIALISTS

Mandarino, Michael J., MD
Orthopedic Surgery
2832 Belmont Avenue
Philadelphia, PA 19131
215-878-1212

Guagliardo, Joseph P., DO
PCOM-Surgery
Orthopedics
4190 City Avenue, Suite 509-R
Philadelphia, PA 19131
215-871-6942

Russin, Simon R., DO
Ophthalmology
301 E. City Avenue, Suite 335
Bala, Cynwyd, PA 19004
610-617-4164

Philadelphia Orthopedic Group
Orthopedic Surgery
2 Bala Plaza, Suite IL-1
Bala Cynwyd, PA 19004
610-667-7712

Lubeck, Joseph S., DO
Neurology
2 Bala Plaza, Suite IL-9
Bala Cynwyd, PA 19004
610-667-0278

Browngoehl, Laurie, MD
Physical Medicine & Therapy
551 W. Lancaster Avenue
Haverford, PA 19041
610-527-8808

OMM Department
4190 City Avenue, Suite 330
Philadelphia, PA 19131
215-871-6425

Parenti, Daniel J., DO
PCOM Intermed Associates
Internal Medicine
4190 City Avenue, Suite 330
Philadelphia, PA 19131
215-871-6337

Lesher, Amy RPT
Body Rebuilders
Physical Therapy
225 City Avenue, Suite 250
Bala Cynwyd, PA 19004
610-668-4055