Gina M. Sowers
Director of Human Resources

Office of Human Resources

Human Services Building
401 Candlelight Drive, Suite 239ccddddddf
Ebensburg, PA 15931
Telephone: (814) 472-1610
Fax: (814) 472-1457 (Payroll-Related Items)
Fax: (814) 472-2127 (All Other Correspondences)

M E M O . . . .

TO: Elected Officials, Department Directors, Supervisors and All Employees

FROM: Bryan J. Beppler, Director of Human Resources

DATE: June 21, 2017

RE: Reporting a Work Related Injury

Non-Emergency:

Immediately following a non-emergency work related injury, the employee and the Elected Official, Department Director, or Supervisor should complete the necessary paperwork in order for a Worker's Compensation claim to be filed. Please contact the Human Resources Department (P: 814-472-1610) to coordinate care. If an employee needs to seek non-emergency medical attention following an injury, he / she is required to seek treatment by one of the providers listed on the *"County of Cambria Workers' Compensation – Panel of Providers"* for a period of ninety (90) days from the date of initial treatment.

Emergency:

If you sustain a work related injury requiring immediate emergency attention, please seek care at the nearest urgent care center or emergency room. After your urgent care / emergency room visit, follow the instructions with respect to completing all the necessary paperwork and contact the Human Resources Department.

Attached, there is a packet of forms requiring completion, along with specific

instructions.

NOTICE REGARDING WORK RELATED INJURIES REPORTING REQUIREMENTS

The injured employee should:

1. Report incident to Elected Official, Department Director or Supervisor.
2. Contact the Human Resources Department (P: 814-472-1610) to coordinate care.
3. Refer to the *"County of Cambria Workers' Compensation – Panel of Providers"*.
4. Complete and forward all the necessary paperwork to the Human Resources Department.

Elected Official, Department Director or Supervisor must complete the following forms and forward to the Human Resources Department:

- *"County of Cambria – Injury and Illness Investigation Report"* form:
  - Complete top portion of this carbon form
  - Separate the forms.
    White copy: To Employee
    Yellow copy: Submit to Human Resources
    Pink copy: To Elected Official, Department Director or Supervisor
    If the employee seeks medical attention, the provider should complete the middle and bottom portions of the form.

- *"Cambria County Accident Investigation Report"* form:
  - This form consists of one (1) page, front and back. All questions must be completed with the exception of the area marked "Human Resources Office Use Only".

The injured employee must complete the following forms and forward to the Human Resources Department:

- *"Employee Statement of Injury"* form
- *"Authorization for Medical Records and Reports"* form
- *"Incident/Accident Procedure Policy Knowledge"* form

COUNTY OF CAMBRIA/INSERVCO

INSERVCO INSURANCE SERVICES, INC.

Workers' Compensation Program: Designated Health Care Providers

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, immediately report the injury to your Supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

- All treatment must be obtained from one of the healthcare providers listed below.

- You must continue to visit one of the healthcare providers listed below if you need treatment for 90 days from the date of your first visit. If one of the providers listed below refers you to another licensed specialist, those services will be paid.

- After this 90-day period, if you still need treatment, you may go to another healthcare provider for treatment as long as you notify your claims adjuster within five (5) days of your visit to a new provider.

- If a listed physician prescribes invasive surgery, you have the right to obtain a second opinion from a physician of your choice. If a second opinion differs from that of the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a detailed treatment plan. If you choose the treatment prescribed in the second opinion, you must receive the treatment for a period of 90 days after the date of your initial visit.

If you are faced with a medical emergency, you may secure initial emergency treatment from any emergency facility. However, after the emergency visit, follow-up treatment must be obtained from one of the following healthcare providers. If you choose to treat with an out-of-state provider, you may be subject to balance billing.

NAME OF PROVIDER	STREET	CITY, STATE, ZIP	PHONE	SPECIALTY
WorkPlace Health	338 Bloomfield St. Ste. 101	Johnstown, PA 15904	814.361.2307	Occupational Health
Hilltop Chiropractic Center	1837 Goucher Street #1	Johnstown, PA 15905	814.255.7292	Chiropractic
Spinos Family Chiropractic	1000 North Center Street	Ebensburg, PA 15931	814.419.8445	Chiropractic
Pagano Chiropractic Clinic	204 South Main Street	Carrolltown, PA 15722	814.344.8740	Chiropractic
Dr. William Carney	415 Napoleon Place	Johnstown, PA 15901	814.534.1650	General Surgery
Dr. Donato Carusi	999 Eisenhower Blvd., Ste. I	Johnstown, PA 15905	814.535.7661	Ophthalmology
Ophthalmic Associates	120 Main Street	Johnstown, PA 15901	814.536.5343	Ophthalmology
Ophthalmic Associastes	1318 Eisenhower Boulevard	Johnstown, PA 15904	814.266.6029	Ophthalmology
Western PA Orthopedics	2 Celeste Drive	Johnstown, PA 15905	814.255.6781	Orthopedics
Conemaugh Physician Group - Plastic Surgery	One Tech Park Drive, Ste. 1200	Johnstown, PA 15901	814.534.6750	Plastic Surgery
Western PA Sports Medicine & Rehab	1253 Scalp Avenue	Johnstown, PA 15904	814.269.9606	Physical Therapy
Western PA Sports Medicine & Rehab	Rt. 22, College Plaza	Ebensburg, PA 15931	814.472.9070	Physical Therapy
Western PA Sports Medicine & Rehab	927 Menoher Boulevard	Johnstown, PA 15905	814.255.6814	Physical Therapy
Vantage Physical Therapy	290 Jamesway Road	Ebensburg, PA 15931	814.472.4921	Physical Therapy
Vantage Physical Therapy	311 Warren Street, #200	Johnstown, PA 15905	814.288.3617	Physical Therapy
Vantage Physical Therapy	1910 Minno Drive, #240	Johnstown, PA 15905	814.255.3566	Physical Therapy
Vantage Physical Therapy	336 Bloomfield Street	Johnstown, PA 15904	814.269.2224	Physical Therapy
Vantage Physical Therapy	3840 William Penn Ave., #10	Nanty Glo, PA 15943	814.749.6385	Physical Therapy
Vantage Physical Therapy	503 Railroad Avenue, Ste. 3	Patton, PA 16668	814.674.2218	Physical Therapy
Vantage Physical Therapy	550 Locust Street, #110	Sidman, PA 15955	814.495.0018	Physical Therapy
X-Cel Physical Therapy	1055 Shoemaker St.	Nanty Glo, PA 15943	814.749.3355	Physical Therapy
X-Cel Physical Therapy	1300 Philadelphia Ave. Ste. 2	Northern Cambria, PA 15714	814.948.8220	Physical Therapy

FOR PRESCRIPTION MEDICATIONS AND DURABLE MEDICAL EQUIPMENT OR TO SCHEDULE PHYSICAL THERAPY, CHIROPRACTIC AND DIAGNOSTIC IMAGING APPOINTMENTS, AND LOCATIONS CLOSE TO YOU, PLEASE CALL KEYSCRIPTS AT 1.866.446.2848.

All of your healthcare provider bills and reports need to be sent to the following address for review and payment in accordance with the Pennsylvania Workers' Compensation Act:

Inservco Insurance Services, Inc. P.O. Box 3899, Harrisburg, PA 17105-3899

Phone: 1.800.356.0438 - Fax: 1.866.356.0438

EMPLOYEE STATEMENT OF INJURY

Date of Report _____

Social Security Number _____

PART I – General Information (Please Print)

Name _____
(First) (M.I.) (Last)

Address _____

_____

Phone # _____ Date of Birth _____/_____/_____ Age _____

Marital Status (Circle One): S M W D # of Children Under 18 _____ Normal Start Time _____AM / PM

Job Title _____ Date of Hire _____

Department _____Supervisor _____

Date of Injury _____Time of Injury _____ AM / PM

PART II – Details of Injury (Please Print)

Please describe in detail: What you were doing, the events and circumstances which were involved in this matter, including times, dates, exact location, tools, equipment, material, and or substances.

_____

_____

_____

_____

_____

_____

_____

Nature and Physical Location of Injury

_____

_____

_____

Witness (s) to Injury _____

I certify that the foregoing statement is true and correct:

_____ _____
(Signature of Employee) (Date) (Witness to Signature) (Date)

COUNTY OF CAMBRIA
INJURY & ILLNESS INVESTIGATION REPORT

EMPLOYEE NAME	AGE	DEPARTMENT	JOB POSITION	DATE OF INJURY	TIME OF INJURY
ADDRESS		LENGTH OF SERVICE ON PRESENT JOB	HOW LONG EMPLOYED	DATE REPORTED TO SUPV.	TIME REPORTED TO SUPV.
		DATE OF BIRTH	NORMAL STARTING TIME	TYPE OF ACCIDENT (LIFTING, STRUCK BY)	LOCATION OF ACCIDENT
EMPLOYEE PHONE NUMBER	MARRIED YES ◯ NO ◯	NUMBER OF CHILDREN UNDER 18	SOC. SEC. NO.	BODY PART INJURED	NATURE OF INJURY (ABRASION, SPRAIN)

BRIEF DESCRIPTION OF INJURY OR ILLNESS:

I UNDERSTAND THAT IF THIS INJURY/ILLNESS IS DETERMINED TO BE NON-WORK RELATED I WILL BE BILLED FOR THIS VISIT.

_____ *EMPLOYEE SIGNATURE*

_____ *SUPERVISOR*

INITIAL MEDICAL EVALUATION REPORT

DIAGNOSIS:

TREATMENT:

WORK STATUS

◯ MAY RETURN TO WORK

◯ MAY RETURN TO WORK WITH NOTED RESTRICTIONS(SEE COMMENTS)

◯ NOT RELEASED (FOLLOW-UP)

COMMENTS:

TYPE/PRINT PHYSICIAN'S NAME _____ SIGNED _____ M.D.

TREATING OR CONSULTING PHYSICIAN

White *- Medical Department* ***Yellow*** *- Human Resources Department* ***Pink*** *- Administration*

CAMBRIA COUNTY ACCIDENT INVESTIGATION REPORT

CASE NUMBER (if applicable)

Department

Location (if different from mailing address)

1. Name of Injured

2. Date of Accident

3. Employee's usual occupation

4. Occupation at time of accident

5. Nature of injury and part of body

6. Time of injury

A. _____ **AM / PM**

B. Time within shift: _____

C. Type of shift: _____

7. Severity of Injury

- ☐ Fatality
- ☐ Lost Workdays-days away from work
- ☐ Lost Workdays-days of restricted activity
- ☐ Medical Treatment
- ☐ First Aid
- ☐ Other. Specify

8. Specific location of accident

_____

_____

On employer's premises? ☐ **Yes** ☐ **No**

9. Phase of employee's workday at time of injury

- ☐ During rest period
- ☐ During meal period
- ☐ Working overtime
- ☐ Entering or leaving plant
- ☐ Performing work duties
- ☐ Other _____

10. Describe how the accident occurred

_____

_____

_____

_____

11. Accident Sequence. Describe in reverse order of occurrence, events preceding the injury and accident. Starting with the injury, and moving backward in time, reconstruct the sequence of events that led to the injury.

A. Injury event _____

B. Accident event _____

C. Preceding event #1 _____

D. Preceding event #2, #3, etc… _____

12. Task and activity at time of accident

General type of task _____

Specific activity _____

Employee was working:

☐ Alone ☐ With crew or fellow worker ☐ Other. Specify

13. Posture of employee

14. Supervision at time of accident

- ☐ Directly Supervised
- ☐ Indirectly Supervised
- ☐ Not Supervised
- ☐ Supervision Not Feasible

15. Causal factors: Events and conditions that contributed to the accident. List causation.

16. Corrective actions. Those that have been, or will be, taken to prevent recurrence.

17. Time frame for corrective action?

Prepared by: _____

Title: _____

Department: _____

Date: _____

HUMAN RESOURCES OFFICE USE ONLY

Received by: _____

Title: _____

Date: _____

Approved by: _____

Title: _____

Date: _____

****Pertinent employee information can be found on the "County of Cambria Injury and Illness Investigation Report".**

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Authorization for Medical Records and Reports

I authorize any physician or nurse who has attended me, or any hospital to which I have been confined, to furnish to my employer, Cambria County and their authorized Workers' Compensation insurance carrier, all available information which may be required regarding my physical condition and treatment rendered.

In addition, if necessary, allow them or any physician appointed by them, to examine any diagnostic imaging of me or any records regarding my physical condition. I also authorize my employer to release any of this information to the occupational health provider. A photostatic copy of this authorization is to be given the same force and effects as the original.

_____

Employee Name (Print) Date

_____

Employee Signature Date

_____

Witness to Signature Date

INCIDENT/ACCIDENT PROCEDURE POLICY KNOWLEDGE

I, _____, understand that failure to follow the established policy and procedure in reporting a work-related injury shall be cause for denial of my compensation claim for the first ninety (90) days.

Policy states that any employee who sustains a work-related injury is obligated to treat with one of the designated healthcare providers set forth on the Primary Doctor Panel for a period of ninety (90) days from the date of immediate treatment.

Failure to follow this procedure is considered a direct violation of established Cambria County policy. Written documentation of the violation will be made and filed in my personnel file for further reference.

Date employee reported incident/accident: _____

Date incident/accident occurred: _____

_____

Employee Signature Date

_____

Witness to Signature Date