TOWNSHIP OF CUMRU

2019

WORKERS' COMPENSATION

PACKET

(Revised: 04/30/2019)

Employee's Acknowledgement of Physician Panel

Notice: Medical treatment for your work injury or occupational illness

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work related injuries and illnesses during the first 90 days of treatment. This list is posted at *THE TOWNSHIP OF CUMRU'S BULLETIN BOARDS* for you to view. Also, you may get a copy of this list from *SUPERVISOR*. If you are injured at work or suffer an occupational illness, you have certain RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Worker's Compensation Act regarding your medical treatment. These rights and duties are summarized below.

Medical treatment: during the first 90 days

- You have the RIGHT to receive reasonable and necessary medical treatment or your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat your work injury or illness
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90 day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not listed on the list.
- IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

Medical treatment: after the first 90 days

- You have the RIGHT to receive treatment from any physician or health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and

Employee's Acknowledgement of Physician Panel

necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.

- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within 5 days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment until you have given this notice.

You signature on this form indicates that you have been informed of an you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I, _____, HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENT TO ME AT (check one);

___ TIME OF HIRE ___ WHEN I WAS INJURED ___ OTHER

EMPLOYEE _____ DATE _____

EMPLOYER REPRESENTATIVE _____
DATE _____

___ EMPLOYEE REFUSES TO SIGN BUT WAS PROVIDED A COPY OF THIS DOCUMENT

Cumru Township

Workers' Compensation Program: Designated Health Care Providers

The following procedures must be followed in case of work related injury or illness:

A. Immediately report the injury to your supervisor.
Any injury you sustain at work must be reported immediately to your supervisor. Failure to do so may delay your benefits or cause you to lose your rights to benefits. Supervisors must promptly report injuries to the appropriate personnel office.

B. Obtain medical care from a provider listed below.

PROVIDER	ADDRESS	PHONE NUMBER	SPECIALITY
1. Jonathon Dreazen, MD	WORKNET 3325 N. 5th St. Highway, Suite 4 Reading, PA 19605	610-939-2391 610-939-2394 FAX	OCCUPATIONAL MEDICINE
2. Martin Matthews	215 N Kenhorst Blvd Reading, PA 19607	610-777-4495	CHIROPRACTIC
3. Michael T. Brown, MD	SPRING RIDGE MEDICAL CENTER 2758 Century Boulevard Wyomissing, PA 19610	610-373-4151	GENERAL SURGERY
4. Moiz M. Carim, MD	CARIM EYE & RETINA CARE CENTER LTD. 2630 Westview Drive Wyomissing, PA 19610	610-376-1981	OPTHALMOLOGY
5. John F. Perry, III, MD	1121 Penn Avenue Wyomissing, PA 19610	610-286-1660	ORTHOPEDIC SURGERY
Optum	Available at any major pharmacy	866-599-5426	PHARMACY
One Call Care Dental	For the nearest location, please call the toll free number.	888-539-0577	DENTIST
One Call Medical Diagnostics	Requires adjuster approval	800-872-2875	DIAGNOSTICS
MedRisk	Requires adjuster approval	800-225-9675	PHYSICAL THERAPY
Hospital	For Emergency Services, please go to the nearest hospital.		HOSPITAL (FOR EMERGENCY SERVICES ONLY)

C. Medical Emergency:
If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. If you choose to treat with an out of state provider, you may be subject to balance billing.

E. For medical treatment to be paid by your employer:
1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians listed above or any specialist to which that provider refers you, if you need treatment, for Ninety (90) days from the date of your first visit. This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
3. After Ninety (90) days, if you still need treatment, you may continue with the same physician or you may choose to go to another physician or health care provider for treatment. If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.
4. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

*For medical groups, all providers are eligible to render medical services.

PHONE (610) 777-1343

FAX (610) 796-0850

TOWNSHIP OF CUMRU

BERKS COUNTY, PENNSYLVANIA
1775 WELSH ROAD
MOHNTON, PA. 19540

WWW.CUMRUTOWNSHIP.ORG

INCIDENT REPORT FORM

DATE OF INJURY ___/___/_____

NAME: _____
STREET ADDRESS: _____
CITY, STATE, ZIP _____
COUNTY: _____
PHONE NUMBER: _____

EMPLOYEE:
MALE _____ FEMALE _____ NUMBER OF DEPENDENTS: _____
MARRIED _____ SINGLE _____ DATE OF BIRTH: _____

OCCUPATION OR JOB TITLE _____

NCCI CLASS CODE (IF KNOWN) _____
EMPLOYMENT STATUS _____

FT-FULL TIME PT-PART-TIME
SL-SEASONAL VO-VOLUNTEER
ZZ-OTHER

IF YOU ARE A VOLUNTEER, PLEASE PROVIDE SOC. SEC. NO. _____

EMPLOYER	TOWNSHIP OF CUMRU
STREET ADDRESS	1775 WELSH ROAD
CITY, STATE, ZIP	MOHNTON, PA 19540
PHONE	(610) 777-1343

COUNTY _____ NAICS CODE _____

FULL PAY FOR DAY OF INJURY: YES _____ NO _____
TIME EMPLOYEE BEGAN WORK: _____ TIME OF OCCURRENCE: _____
LAST DAY WORKED _____ DATE DISABILITY BEGAN _____
DATE EMPLOYER NOTIFIED _____ DATE RETURED TO WORK _____
DATE OF HIRE _____
CONTACT NAME _____ CONTACT PHONE NUMBER _____

TYPE OF INJURY OR ILLNESS: _____
_____

PARTS OF BODY AFFECTED: _____
_____

CAUSE OF INJURY: _____
_____

DID INCIDENT OCCUR ON EMPLOYER'S PREMISES: _____

LOCATION OF INCIDENT: _____

IF OUT OF STATE, SPECIFY STATE OF INJURY: _____

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED: _____

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED: _____

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED _____

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

_____

IDENTIFY THE DIRECT CAUSE, BUT DO NOT STOP THERE. CONTINUE YOUR ANALYSIS UNTIL YOU IDENTIFY THE ROOT CAUSES, ASK WHY UNTIL IT NO LONGER MAKES SENSE TO DO SO. THIS WILL HELP YOU TO IDENTIFY THE ROOT CAUSE.

INDIRECT OR ROOT CAUSES (CHECK APPROPRIATE BOX)

- HABIT (REPEATED BEHAVIOR WITHOUT CONSCIOUS THOUGHT, E.G., IMPROPER LIFTING)
- HABIT INTERFERENCE (UNANTICIPATED INTERUPTION OF HABITUAL BEHAVIOR, E.G. SUDDEN LOUD NOISE)
- PHYSICAL OR MENTAL IMPAIRMENT (PHYSIOLOGICAL FACTORS SUCH AS FATIGUE)
- LACK OF KNOWLEDGE OR SKILL (ABSENCE OF NECESSARY INFORMATION, NO TRAINING, NEW EMPLOYEE, UNFAMILIAR JOB TASK)
- LACK OF POLICIES OR PROCEDURES (OR LACK OF ENFORCEMENT)
- BARRIERS (SAFETY VERSUS TIME, SAFETY VERSUS CONVENIENCE, SAFETY VERSUS COMFORT, ETC.)
- TRAPS (SPILLS, HOUSEKEEPING, CLUTTER, UNGUARDED/FAULTY MACHINERY, ETC.)
- CONFLICTING MOTIVATIONS (IMPROPER INCENTIVES, WORKING RELATIONSHIPS, LACK OF TEAM ENVIRONMENT, ETC.)

DIRECT CAUSE OR IMMEDIATE UNSAFE ACTS OR CONDITIONS REVEALED: _____

EXPLAIN THE DIRECT AND INDIRECT CAUSES LISTED ABOVE: _____

ACTIONS NEEDED TO PREVENT RECURRENCE: _____

PERSON OR PERSONS RESPONSIBLE FOR CORRECTIVE ACTION: _____

IF FATAL, GIVE DATE OF DEATH _____

PHYSICIAN/HEALTH CARE PROVIDER_____
FIRST NAME: _____ LAST NAME: _____
STREET _____ CITY _____STATE _____ZIP _____

INITIAL TREATMENT ___ NO MEDICAL TREATMENT ___ MINOR BY EMPLOYEE ___ CLINIC/HOSPITAL
___ PANEL PHYSICIAN ___ EMPLOYEE PHYSICIAN ___ EMERGENCY CARE
___ HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM: ____/____/____ POLICY PERIOD TO: ____/____/____

HOSPITAL NAME: _____
STREET _____ CITY _____ STATE _____ ZIP _____

POLICY/SELF INSURED NUMBER _____

WITNESS NAME _____ WITNESS PHONE NUMBER _____

WITNESS STATEMENT (INCLUDE DETAILS OF WHAT WAS SEEN OR HEARD AT THE TIME OF THE INCIDENT)

_____
_____
_____
_____

WITNESS NAME: _____
WITNESS PHONE NUMBER _____

WITNESS STATEMENT (INCLUDE DETAILS OF WHAT WAS SEEN OR HEARD AT THE TIME OF THE INCIDENT)

_____
_____
_____
_____

PERSON COMPLETING THIS FORM:

NAME: _____

TITLE: _____

PHONE: _____ DATE PREPARED: _____

DESCRIPTION OF ACCIDENT/EMPLOYEE'S STATEMENT (DESCRIBE IN DETAIL EXACTLY WHAT HAPPENED)

_____
_____
_____
_____
_____

DESCRIPTION OF INJURY OR PROPERTY DAMAGE

_____
_____
_____
_____
_____

WORKERS' COMPENSATION FRAUD IS A CRIME PUNISHABLE BY A FINE UP TO $50,000 AND/OR IMPRISONMENT UP TO SEVEN YEARS! FRAUD INCLUDES BUT IS NOT LIMITED TO:

- FAKED INJURY
- DELIBERATE INJURY
- PHONY MEDICAL OR TREATMENT BILLS
- NON WORK RELATED INJURY
- MISREPRESENTATION OF LOST WAGES OR LOST TIME

SUPRVISOR SIGN AND DATE_____

I CERTIFY THAT THE STATEMENTS MADE ON THIS DOCUMENT ARE TRUE AND ACCURATE TO THE BEST OF MY ABILITY. I ALSO UNDERSTAND THAT WORKERS COMPENSATION FRAUD IS A CRIME AND IS PUNISABLE AS LISTED ABOVE.

_____

SUPERVISORY ACKNOWLEDGEMENT, SIGNATURE & DATE

EMPLOYEE SIGN AND DATE_____

I CERTIFY THAT THE STATEMENTS MADE ON THIS DOCUMENT ARE TRUE AND ACCURATE TO THE BEST OF MY ABILITY. I ALSO UNDERSTAND THAT WORKERS COMPENSATION FRAUD IS A CRIME AND IS PUNISHABLE AS LISTED ABOVE.

_____

EMPLOYEE ACKNOWLEDGEMENT, SIGNATURE & DATE

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME: AmTrust North America

STREET: P O BOX 94405

Cleveland, OH 44101

PHONE: 1-888-239-3909

Completed by Human Resources

DATE RECEIVED BY HUMAN RESOURCES: _____

EMPLOYEES SOCIAL SECURITY NUMBER: _____

EMPLOYER FEIN: 23-6000288

SIC CODE: _____

CONTACT PERSON'S NAME: Peggy A. Carpenter 610-777-1343 ext. 110

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY (MONTH - DAY - YEAR)

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY | STATE | ZIP CODE

COUNTY | PHONE NUMBER

EMPLOYEE: MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ | NUMBER OF DEPENDENTS | DATE OF BIRTH (MONTH - DAY - YEAR)

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN) | EMPLOYMENT STATUS (FT = Full-time, PT = Part-time, SL = Seasonal, VO = Volunteer, ZZ = Other)

EMPLOYER: Cumru Township

STREET ADDRESS: 1775 Welsh Road

CITY: Mohnton | STATE: PA | ZIP CODE: 19540-

SIC CODE: 9111 | EMPLOYER FEIN: 23-6000288 | PHONE NUMBER: 610-777-1343

COUNTY: BERKS | NAICS CODE

FULL PAY FOR DAY OF INJURY? YES ☐ NO ☐ | TIME EMPLOYEE BEGAN WORK AM ☐ PM ☐ | TIME OF OCCURRENCE AM ☐ PM ☐

344 1197-1

LAST DAY WORKED (MONTH - DAY - YEAR) | DATE DISABILITY BEGAN (MONTH - DAY - YEAR)

DATE EMPLOYER NOTIFIED (MONTH - DAY - YEAR) | DATE RETURNED TO WORK (MONTH - DAY - YEAR) | DATE OF HIRE (MONTH - DAY - YEAR)

CONTACT FIRST NAME | CONTACT PHONE NUMBER

CONTACT LAST NAME: F610-796-8128

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

LIBC-344 REV 1-01

(OVER)

LIBC 344

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES ☐
NO ☐

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES ☐
NO ☐

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES ☐
NO ☐

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE.

IF FATAL, GIVE DATE OF DEATH
MONTH - DAY - YEAR

INITIAL TREATMENT:
- ☐ NO MEDICAL TREATMENT
- ☐ MINOR BY EMPLOYEE
- ☐ CLINIC / HOSPITAL
- ☐ PANEL PHYSICIAN
- ☐ EMPLOYEE PHYSICIAN
- ☐ EMERGENCY CARE
- ☐ HOSPITALIZED MORE THAN 24 HOURS

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:

STREET

CITY STATE ZIP

HOSPITAL NAME:

STREET

CITY STATE ZIP

POLICY PERIOD FROM: 04-13-2019
MONTH DAY YEAR

POLICY PERIOD TO: 04-13-2020
MONTH DAY YEAR

POLICY/SELF INSURED NUMBER: WWC3413439 0

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:

NAME: Peggy Carpenter <pcarpenter@cumrutownship.org>

TITLE: Business Personnel Administrator

PHONE: (610) 777-1343

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)

NAME: AmTrust North America P 888-239-3909

STREET P O Box 94405 F 678-258-8399

CITY Cleveland STATE OH ZIP 44101

BUREAU CODE: 2248 FEIN:

DATE PREPARED
MONTH - DAY - YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.