BETHLEHEM AREA SCHOOL DISTRICT

TO: BASD Employee

FROM: Employee Benefits Administrator

RE: Work Injury Packet

Attached is the Workers' Compensation Injury Packet including the current panel of authorized providers. You are required to complete, read, and sign all attached forms.

- Workers' Compensation Occupational Injury/Incident Report (All questions must be answered completely including specific detail, i.e. identifying the exact injured area along with where, when, and how the injury occurred.)
- List of Authorized Panel Providers
- Employee's Rights & Duties Under Section 306 (F.1) of The Pennsylvania Workers' Compensation Act
- Authorization to Release, Use and Disclose Protected Health Information

All of the forms listed above must be completed and returned to Human Resources within 48 hours or you may be required to provide a written statement, explain the reason why it was reported late, and provide an eyewitness verification.

The completed forms can be placed in the inter-district mail to Kelly Burkholder, Employee Benefits Administrator, delivered to Human Resources in the Education Center, or emailed to **WorkInjuryReport@basdschools.org.**

Where to Seek Medical Treatment for Injuries: With the exception of severe bleeding, unconsciousness, obvious fracture, or any other obvious emergency, you are not to seek treatment at a hospital emergency room, nor should you call 911 (Emergency Medical Services).

If you are seeking medical treatment, you must be treated by one of our Panel Providers (see p. 4 of this packet). You also must complete an injury report and notify Kelly Burkholder, Employee Benefits Administrator, (610) 861-0500, extension 60210, of your injury. **You cannot go to a family doctor (private physician) for a work-related injury. Private insurance will not pay for a work-related claim.**

Claim Number: When your Workers' Compensation Injury Report has been entered into the Workers' Compensation system, you will receive an email with your Claim Number and adjuster information. This information will be sent to your BASD email address from WorkInjuryReport@basdschools.org. Carefully read all of the information provided in this email.

Lost Time: Lost time due to a work-related injury must be immediately reported to Kelly Burkholder, Employee Benefits Administrator, (610)861-0500, extension 60210 or emailed to **WorkInjuryReport@basdschools.org.**

Returning to work: Before you can return to work after treatment for a work-related injury you must provide a release from the treating provider to your supervisor and the Employee Benefits Administrator. **Medical appointments relating to the work-related injury should be made before or after work hours**. Workers' Compensation does not pay for time off for medical appointments once you have returned for regular duty.

If you have any questions, please contact Kelly Burkholder, Employee Benefits Administrator at 610-861-0500, ext. 60210 or kburkholder@basdschools.org.

BETHLEHEM AREA SCHOOL DISTRICT

WORKERS' COMPENSATION OCCUPATIONAL INJURY/DISEASE REPORT

EMPLOYEE INFORMATION (Please Print)

Last Name	First Name	☐ Single ☐ Married ☐ Female ☐ Male
Date of Birth / Social Security Number	Mailing Address	
City	State	Zip Code
Home Phone Number / Cell Phone Number	Date Of Injury	Time of Injury ☐ a.m. ☐ p.m.
Supervisor / Hire Date / Wage Information Hourly _____ Salary _____		Shift Start Time ☐ a.m. ☐ p.m.

Are you employed elsewhere? ☐ Yes ☐ No If yes, provide employer's name, address, and phone number:

_____

_____

CHECK ALL BUILDINGS YOU ARE ASSIGNED TO

- ☐ Asa Packer Elementary
- ☐ Calypso Elementary
- ☐ Clearview Elementary
- ☐ Donegan Elementary
- ☐ Farmersville Elementary
- ☐ Fountain Hill Elementary
- ☐ Freemansburg Elementary
- ☐ Governor Wolf Elementary
- ☐ Hanover Elementary
- ☐ James Buchanan Elementary
- ☐ Lincoln Elementary
- ☐ Marvine Elementary
- ☐ Miller Heights Elementary
- ☐ Spring Garden Elementary
- ☐ Thomas Jefferson Elementary
- ☐ William Penn Elementary
- ☐ Broughal Middle School
- ☐ East Hills Middle School
- ☐ Nitschmann Middle School
- ☐ Northeast Middle School
- ☐ Freedom High School
- ☐ Liberty High School
- ☐ Education Center
- ☐ Maintenance
- ☐ Transportation

JOB CLASSIFICATION

- ☐ Admin/Supervisory (IMD)
- ☐ Childcare Aid
- ☐ Clerk/Secretary
- ☐ Custodial
- ☐ Maintenance
- ☐ NIMD
- ☐ Teacher
- ☐ Teacher Aide
- ☐ Transportation
- ☐ Other _____

CAUSE

- ☐ Burn, Scald, Exposure, Contact Injury
- ☐ Caught in, under, or between
- ☐ Cut, Puncture, Scrape, Injuredby
- ☐ Fall, Slip, or Trip
  - ☐ On Fluids
  - ☐ Ice/Snow
  - ☐ Different Level
  - ☐ Same Level
- ☐ Repetitive Motion Injury
- ☐ Strain or Injury by
  - ☐ Lifting
  - ☐ Pushing/Pulling
- ☐ Striking Against or Stepping On
- ☐ Struck or Injured by
  - ☐ Flying Object
  - ☐ Student

TYPE OF INJURY

- ☐ No apparent injury
- ☐ Amputation
- ☐ Burn
- ☐ Contusion
- ☐ Crushing
- ☐ Electrical Shock
- ☐ Cumulative trauma (repetitive motion)
- ☐ Foreign Body (e.g., in eye)
- ☐ Laceration/Cut
- ☐ Puncture (e.g., needle stick)
- ☐ Sprain/Strain
- ☐ Other: _____

INCIDENT (Please Print) - Employee's explanation of injury. Please provide detail of body part injured and explanation of how injury occurred. Attach a separate sheet if necessary. Please note: Any workspace accident occurring while operating a district vehicle will be subject to a drug and alcohol test.

Were you injured while performing job duties? ☐ Yes ☐ No

Specific illness / injured body part(s): _____ ☐ Right Side ☐ Left Side ☐ Both Sides ☐ Multiple Parts

If back injury, specify: ☐ Upper ☐ Mid ☐ Lower

Please describe in detail **(1)** ***WHAT YOU WERE DOING*** **(2)** ***HOW YOU WERE INJURED*** **(3)** ***WHAT YOU INJURED.***
Example: I was (1) up on a ladder replacing the fluorescent lighting tubes in the ceiling, and (2) I slipped, fell off the ladder, and (3) landed on the floor in a sitting position with my right leg twisted under me.*

_____

_____

_____

Please describe in detail ***WHAT YOU FELT PHYSICALLY.***
Example: I felt a tearing and burning sensation in my knee when I hit the floor. Upon trying to get up, I had shooting pains in my low back and required help to walk to a chair.*

_____

_____

_____

Did injury take place on employer's premises? ☐ Yes ☐ No

If yes, provide exact location of incident: _____

WITNESS(ES)

Last Name	First Name	Title
Last Name	First Name	Title

MEDICAL TREATMENT

Did you seek medical treatment for injury? ☐ Yes ☐ No School Nurse _____	Name of provider

SIGNATURES

Employee's Signature _____ Date _____

Supervisor's Comments:

_____

_____

_____

Supervisor's Signature _____ Date _____

TO BE COMPLETED BY HUMAN RESOURCES

Loss Type

☐ Incident Only ☐ Medical Only ☐ Temporary Transitional Duty ☐ Off work

Clear Spring Property and Casualty Group
PO Box 6762 Pittsburgh, PA 15212
Phone: 1-888-280-5225

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.

Clear Spring Property and Casualty Group
PO Box 6762 Pittsburgh, PA 15212
Phone: 1-888-280-5225

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Pennsylvania Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his/her employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. If you are faced with a medical emergency, you may secure assistance from a hospital or physician/health care provider of your choice. However, once the emergency no longer exists, the injured employee must treat with a listed provider for the remainder of the ninety (90) day period.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and your employer will pay for that treatment.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. Your employer will pay for this treatment unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from non-designated health care provider and only if that notice is provided to your employer within five (5) days of the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more than five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should a designated health care provider prescribe invasive surgery, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT AS SET FORTH HEREIN

Employee Name	Employee Signature	Date

EMPLOYEE RE-NOTIFICATION AT OR NEAR THE TIME OF THE CLAIMED WORK INJURY

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Pennsylvania Workers' Compensation Act. I have received a copy of this workers' compensation employee notification form.

Employee Name	Employee Signature	Date

Clear Spring Property and Casualty Group
PO Box 6762 Pittsburgh, PA 15212
Phone: 1-888-280-5225

AUTHORIZATION TO RELEASE, USE AND DISCLOSE PROTECTED INFORMATION
45 CFR 164.508 & 164.512 (HIPAA)

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ SS# - -

CLAIM #: _____

I authorize the disclosure and release of any and all protected health information including but not limited to: WRITTEN MEDICAL RECORDS: any and all medical records, all in patient and outpatient charts and records, hospital charts and records, doctor and nurse notes, emergency room records, correspondence, memoranda, physical therapy and rehabilitation records, patient questionnaire forms, patient history forms, social service records, laboratory records and diagnostic reports. PRESCRIPTION RECORDS: any and all prescription records, original doctor's prescription forms, refill records and pharmacy records. BILLING: any and all billing records, including itemized statements of charges, payments, all insurance records, including all claims, claim forms, correspondence, payments and reports. EMPLOYMENT RECORDS: any and all employment records including wage information and personnel documents. BUREAU RECORDS: any and all Bureau of Workers' Compensation records for any and all workers' compensation claims. INSURANCE RECORDS: any and all documents regarding any insurance claim involving a physical injury including, but not limited to, all medical records, correspondence, medical history, police reports, payment ledgers and all other documents contained in the claim(s) file This authorization applies to all medical records, injuries, medical history, employment and physical condition regardless of the time of occurrence both prior to and subsequent to my signature on this form regardless of time of occurrence.

HIV, Mental Health, and Drug & Alcohol Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not Release: _____ HIV _____ Mental Health _____ Drug & Alcohol

This protected health information is disclosed for the following purpose: **Workers' Compensation Claim**

This information will be used for the purpose of verifying, evaluating and/or negotiating the individual's claim. This information is not required for obtaining treatment.

You are authorized to release the above records to the following: Clear Spring Property and Casualty Group and its agent(s) for the purpose of medical record procurement.

I have the right to revoke this Authorization, in writing, by sending written notification to the covered entity. I understand that my decision to revoke the authorization may result in a denial of my workers' compensation claim for failure to comply with a medical record request, but it will not affect my ability to obtain treatment from any covered entity. I further understand that a revocation is not effective to the extent that you have relied upon my authorization to disclose protected health information prior to revocation. In addition, I understand that the information may be re-disclosed and no longer subject to protection. I understand that I have the right to:

- Inspect or copy the individually identifiable health information to be disclosed.
- Refuse to sign this authorization, subject to any possible sanctions imposed by the Pennsylvania Workers' Compensation Act and its Regulations.
- That I am entitled to a copy of this completed authorization form.

This form also constitutes authority for you to produce and make photostatic copies of all such records, and to forward same by mail to the approved referenced representative. A photostatic copy of this Authorization shall have the same effect as the original.

This authorization shall remain valid until the claim has been legally concluded for which these records are sought.

_____ _____
Signature of Individual/Legal Representative **Date**

_____ _____
Printed Name of Individual/Legal Representative **Relationship to Individual**

Bethlehem Area School District - Bethlehem 18017

Your Workers' Compensation Insurance Carrier is:

Clear Spring
Property and Casualty Group

PO Box 6762 Pittsburgh, PA 15212
Phone: 1-888-280-5225

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR WORK INJURY.

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 ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. 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.
5. 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 physician's 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.
6. 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.

FOR ASSISTANCE IN SCHEDULING APPOINTMENTS, PLEASE CALL PREMIER COMP TOLL FREE 24 HOURS/7 DAYS A WEEK AT 1-888-594-4001

Name	Address	Phone	Area of Specialty
Concentra Medical Centers Walk-in Available	6990A Snowdrift Road Allentown, PA 18106 Location #: 484-742-0880	1-888-594-4001	Occupational Medicine
Concentra Medical Centers Walk-in Available	90 South Commerce Way, Suite 100 Bethlehem, PA 18017 Location #: 484-820-0260	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	153 Brodhead Road Bethlehem, PA 18017 Location #: 484-526-3223	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	501 Cetronia Road, Suite 105 Allentown, PA 18104 Location #: 484-526-3223	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	5445 Lanark Road Center Valley, PA 18034 Location #: 484-526-5750	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	2003 Sullivan Trail Easton, PA 18040 Location #: 484-503-6470	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	2250 Route 100 Macungie, PA 18062 Location #: 484-822-5100	1-888-594-4001	Occupational Medicine
St. Luke's Occupational Medicine Walk-in Available	614 Delaware Avenue Palmerton, PA 18071 Location #: 484-526-3223	1-888-594-4001	Occupational Medicine
OAA (Multiple Locations)	2045 Westgate Drive, Suite 101 Bethlehem, PA 18020 Location #: 610-973-6200	1-888-594-4001	Orthopedics
St. Luke's Orthopedic Care (Multiple Locations)	801 Ostrum Street Bethlehem, PA 18015 Location #: 484-526-1735	1-888-594-4001	Orthopedics
St. Luke's Neurology (Multiple Locations)	1417 Eighth Avenue Bethlehem, PA 18018 Location #: 484-526-5210	1-888-594-4001	Neurology
Bethlehem Eye Associates	800 Eaton Avenue, 1st Floor Bethlehem, PA 18018 Location #: 610-691-3335	1-888-594-4001	Ophthalmology
OAA (Multiple Locations)	250 Cetronia Road, 2nd Floor Allentown, PA 18104 Location #: 610-973-6350	1-888-594-4001	Chiropractic

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Optum	Call Toll Free for Closest Location	1-800-964-2531	Pharmacy

Panel Date: 6/24/2024