

**NOTICE TO EMPLOYEES OF BETHLEHEM AREA SCHOOL DISTRICT
IN CASE OF WORK-RELATED INJURY**

1. If you suffer a work-related injury, you *must* report all incidents to your administrator or supervisor immediately. The district will pay for reasonable surgical, medical services, medicines, and supplies as well as orthopedic appliances and prostheses, including training in their use.
2. In order to ensure that reasonable medical treatment will be paid by the district, you *must* select one of the designated health care providers listed below.
3. If you need treatment, you *must* continue to visit one of the providers listed below for ninety (90) days from the date of your first visit.
4. If you still need treatment after this ninety (90) day period, you may choose to go to another health care provider for treatment. You *must* notify the district of any change within five (5) days of your visit to this nondesignated health care provider of your choice.
5. If one of the providers listed below refers you to a licensed specialist, the district will pay the bill for these services.
6. If you are faced with a medical emergency, you *must* secure assistance from one of the following:

DESIGNATED HEALTH CARE PROVIDERS

Occu-Med Resources	St. Luke's North 153 Brodhead Road, Bethlehem, PA 18017	610-954-3223
HealthWorks – Bethlehem	1770 Bathgate, Suite 200, Bethlehem, PA 18017	484-884-2249
Health Works Health Center at Bethlehem Township	2101 Emrick Boulevard, Bethlehem, PA 18020 (Route 33 and Freemansburg Avenue)	610-866-9675
HealthWorks – Allentown	1243 South Cedar Crest Boulevard, Allentown, PA 18103	610-402-9285
HealthWorks Health Center at Trexlertown	6900 Hamilton Boulevard, Trexlerstown, PA 18087	610-402-0047
Chiropractor	Paul Duffy, D.C. Coordinated Health Systems 2300 Highland Avenue, Bethlehem, PA 18020	610-865-4880 Ext. 8310

DESIGNATED HEALTH CARE PROVIDERS – EMERGENCY ONLY

Emergency Department	St. Luke's Hospital 801 Ostrum Street, Bethlehem, PA 18015	610-954-4500
Emergency Room	Lehigh Valley Hospital – Muhlenberg 2545 Schoenersville Road, Bethlehem, PA 18017	484-884-2521
Emergency Department	Sacred Heart Hospital 421 Chew Street, Allentown, PA 18102	610-776-4622
Emergency Department	Lehigh Valley Hospital Center Cedar Crest Boulevard & I-78, Allentown, PA 18104	610-402-8111

QUESTIONS SHOULD BE REFERRED TO PMA CUSTOMER SERVICE – 1-884-476-2669

(OVER)

JULY 1, 2008 :dw

**BETHLEHEM AREA SCHOOL DISTRICT
EMPLOYEE REPORT OF WORK RELATED ACCIDENT
(Workers' Compensation)**

Employee Name _____ (male – female) Telephone No. _____
Include Area Code

Address _____
County _____
Street City State Zip Code

Occupation/ Employment Status Date of Birth _____
Job Title _____
circle (Full-time) (Part-time)

Social Security No. _____ Married (yes) (no) Number of Dependents _____

Date of Hire _____ Normal Work Starting Time _____ (AM) (PM) Hours Worked per Week _____

Date of Injury _____ Time of Injury _____ Starting Time on Date Injured _____ Date Injury Reported _____

Accident Reported To _____ Reported By _____

Who Witnessed Accident? _____
Name Address Telephone No. Include Area Code

Was Present Injury Caused by Negligence of Someone Not Working for BASD? _____

If Yes, Name and Address of Person _____

Building/Location Where Accident Occurred _____

Did Injury or Disease Occur Because of Mechanical Defect? (yes) (no) (If Yes, Describe Below) Unsafe Act? (yes) (no) (If Yes, Describe Below)

Describe the Injury – Including Parts of Body Affected _____

Did You Stop Work as a Result of Your Accident? (yes) (no) If yes, When? _____ What Date Did You Return to Work? _____

What Were You Doing When Injured? (Be specific. If using tools or equipment or handling material, name them and tell what you were doing with them.)

How Did Injury Occur? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to injury or disease.)

Were Safeguards or Safety Equipment Provided? (yes) (no) Were Safeguards or Safety Equipment Used? (yes) (no)
circle (yes) (no) circle (yes) (no)

Did You Receive Medical Treatment? (yes) (no) Date of First Treatment? _____

From Whom Did You Receive First Medical Treatment? _____

Are You Still Under Medical Treatment? (yes) (no) How Often Do You Receive Treatment? _____

Name of Doctor Treating You _____

Address of Doctor _____

Do You Have Any Chronic Illness(es) or Prior Injuries? (yes) (no) If so, Complete the Following:

Date of Chronic Illness or Prior Injuries	Nature of Chronic Illness or Prior Injuries
_____	_____
_____	_____
_____	_____

I am aware of the designated health care provider list and understand failure to seek treatment from a panel physician may result in nonpayment of bills.

I affirm that my answers to the questions on this report and any other information which I have furnished in connection with this report are true and correct, and that I have not knowingly withheld any facts or circumstances.

Employee Signature _____ Date _____

Received By (Principal/Supervisor) _____ Date _____

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.

WORKER'S COMPENSATION
EMPLOYEE NOTIFICATION

Part 2

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.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act.

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

Employee signature _____ **Date** _____