Bellefonte Area School District - Bellefonte (16823)
NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES
Eastern Alliance Insurance Group
PO Box 83777
Lancaster, PA 17608-3777
(717) 396-7095
(855) 533-3444

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 the insurance company, you must select from one of the following health care providers:

3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.

4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.

5. 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.

6. 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.

7. 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.

PLEASE CALL EASTERN ALLIANCE'S SCHEDULING SERVICES TOLL FREE AT 1-855-572-3926 FOR ASSISTANCE IN SCHEDULING PHYSICAL/OCCUPATIONAL THERAPY OR CHIROPRACTIC REHABILITIATION OR SEND THE REFERRAL FORM TO easternreferrals@medrisknet.com

Name	Address	Scheduling	Area of Specialty
MedExpress Urgent Care	1613 N Atherton St. State College, PA 16823	814-238-1066	Occupational Medicine
The Work Center at Lock Haven	24 Cree Drive Lock Haven, PA 17745	570-893-5010	Occupational Medicine
Mt. Nittany Physicians Group	1700 Old Gatesburg Rd. Suite 200 State College, PA 16803	814-237-4321	Orthopedics
University Orthopedics Center	101 Regent Court State College, PA 16801	814-231-2101	Orthopedics
Penn State Heath Sports Medicine & Physical Therapy (Wayne J Sebastianelli)	1850 E. Park Avenue Suite 112 State College, PA 16803	814-865-3566	Orthopedics
Mt. Nittany Physicals Group	905 University Drive State College, PA 16801	814-238-8418	General Surgery
Centre Eye Physicians & Surgeons	507 Locust Lane State College, PA 16801	814-237-4105	Ophthalmology
MedRisk PT/OT Network	Call Toll Free for Scheduling	1-855-572-3926	Physical & Occupational Therapy
MedRisk Chiro Network	Call Toll Free for Scheduling	1-855-572-3926	Chiropractic Care
One Call Care Management	Call Toll Free for Closest Location	1-800-872-2875	MRI
Carlisle Medical Inc.	Call Toll Free for Closest Location	1-800-553-1783	DME
Key Scripts	Call Toll Free for Closest Location	1-866-446-2848	DME/Pharmacy
Homelink	Call Toll Free for Closes Location	1-800-571-2943	DME/Pharmacy

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Worker's Compensation Act. I hereby acknowledge that I have been informed of and understand my rights and duties under the above provisions of the Worker's Compensation Act.

Employee Signature:______________________________ Date:____________

Supervisor Signature:______________________________ Date:____________

HR Signature:______________________________ Date:____________

Revised April 2021

(Human Resources Only) Claim #:___________________

Bellefonte Area School District-Employee Accident Report

All employees of the Bellefonte Area School District are covered by Worker's Compensation.
A report of an accident *must* be reported to the Department of Labor & Industry within 15 days after injury. Therefore, we ***must*** make a report to the insurance agency as soon as possible after the accident. This form ***must*** be filled out in detail or it will be returned requesting that you provide further information. In returning form back for further information may delay the process. After completing the form, please return to the Human Resources Office promptly.

Employee Information:

Employee Name:_______________________ Date of Hire:_________ Contact #:____________

Date of Birth:________________ Social Security Number_______-_______-________

Street Address:_________________________ City:___________ Zip:_________ County:__________

Work Status: ____FT ____PT Job Title:___________________ Working Hours:_______start time AM or PM
_______ stop time AM or PM

Marital Status:___S ____M _____D

Do you have children under age of 18? ___Y____N If yes, how many?_______

Accident Information:

Date of Accident:_______________ Time of Accident:_____________

Did you continue working day of accident:______ Yes ______No
*If NO, list date last worked:_____________
_____________ Date disability began (if none, write none)
_____________ If you are back to work, give date

School in which accident occurred:_______________________________

Describe **in detail** how the injury occurred (**what you were doing when it happened**):

____

____

Describe **in detail** the type of injury (bruise, laceration, broken bone(s)):

____

List body part(s) affected:____________________ Side of body affected: ________Left ________ Right

Please check all that apply:

___No Medical Treatment
___Hospitalized more than 24 hrs.
___Employee Physician
___Panel Physician
___Minor treatment by injured employee to self
___Emergency Care
___Clinic
___Treated by school nurse

Name & address of Attending Physician/and or hospital involved:

____

____

If treated by school nurse:

Name of school nurse treated by:_______________________ Nurse Signature:_______________________

Treatment provided by school nurse:____

Employee Signature:____ Date: _______________

Witness Name (of the actual injury happening): ____

Witness Signature:____ Phone: _____________

You must also read and sign the reverse side of this form. Please be sure to keep a copy of this form for your files.

Revised April 2021