

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 or (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 REHABILITATION OR SEND THE REFERRAL FORM TO
easternreferrals@medrisknet.com**

| Name | Address | Scheduling | Area of Specialty |
|--|--|-------------------|--|
| MedExpress Urgent Care | 1613 N Atherton Street, Suite B State College, PA 16803 | 814-238-1066 | Occupational Medicine |
| The Work Center at Lock Haven | 24 Cree Drive Lock Haven, PA 17745 | 570-893-5510 | Occupational Medicine |
| Geisinger General Surgery | 132 Abigail Lane Port Matilda, PA 16870 | 1-800-230-4565 | General Surgery |
| University Orthopedics Center | 101 Regent Court State College, PA 16801 | 814-231-2101 | Orthopedics |
| Penn State Health Sports Medicine & Physical Therapy (Wayne J Sebastianelli) | 1850 E. Park Avenue Suite 112 State College, PA 16803 | 814-865-3566 | Orthopedics |
| Centre Eye Physicians & Surgeons | 507 Locust Lane State College, PA 16801 | 814-237-4105 | Ophthalmology |
| MedRisk | Call Toll Free for Scheduling | 1-855-572-3926 | Physical & Occupational Therapy 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 | Durable Medical Equipment |
| Key Scripts | Call Toll Free for Closest Location | 1-800-446-2848 | Pharmacy |
| Key Scripts | Call Toll Free for Closest Location | 1-866-446-2848 | Durable Medical Equipment |
| Homelink | Call Toll Free for Closest Location | 1-800-571-2943 | Durable Medical Equipment |

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: _____

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:

- | | |
|---|--|
| <input type="checkbox"/> No Medical Treatment | <input type="checkbox"/> Minor treatment by injured employee to self |
| <input type="checkbox"/> Hospitalized more than 24 hrs. | <input type="checkbox"/> Emergency Care |
| <input type="checkbox"/> Employee Physician | <input type="checkbox"/> Clinic |
| <input type="checkbox"/> Panel Physician | <input type="checkbox"/> 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.