Please have the employee complete this Workers’ Compensation Signature Packet as soon as an injury report is completed using our on-line first report of injury system.

1. Workers’ Compensation Employee Notification Form
2. Employee Description of Injury Form (completed by the employee)
3. Workers’ Compensation Information Sheet
4. OPP Accident Investigation Form (completed by the supervisor)

Please return signed documents to:

Office of Physical Plant
Human Resources Department
102 Physical Plant Building
University Park, PA 16802

Phone: (814) 863-2340
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 ___________ for you to view. Also, you may get a copy of this list from ___________.

http://ohr.psu.edu/workers-compensation/.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers’ 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 for 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 you for 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 treatment for 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 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 other 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 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 five 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 received until you have given this notice.

Your signature on this form indicates that you have been informed of and 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 PRESENTED TO ME AT (check one):

☐ TIME OF HIRE ☐ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: __________________________ Website: ____________ DATE: ____________

EMPLOYER REPRESENTATIVE: __________________________ DATE: ____________

(OVER)
REQUIREMENTS FOR EMPLOYER’S LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.

2. At least 3 of the health care providers on the list must be physicians.

3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).

4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.

5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.

6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers’ compensation insurance company.

NOTE: Your employer’s list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

______________________________________________
BUREAU OF WORKERS’ COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
(717) 772-4447 (local and calls outside PA)
EMPLOYEE DESCRIPTION OF INJURY FORM

Date of injury: _________________  Time: _________________AM/PM

Date injury was reported: _________________  Reported to _______________________________

PSU ID #_____________________

Name of Injured Person (Please Print):_____________________________________________________________________

Address: ______________________________________________________________________________________

Phone Number(s) ___________________________  Date of Birth: ___________________ Male_______ Female______

Type of Injury: _____________________________  Body Part(s) affected_______________________________

Details of injury
1. Please describe in your own words how the injury occurred. Include specific details such as equipment used, tools, etc. (Please Print)

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

2. Please describe where the injury occurred and what activity you were performing when the injury occurred. (Please Print)

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

(Continue on the back of this form to add additional details.)

Witness to the injury: __________________________  __________________________

Name                                                      Contact Number

Signature of Employee_________________________________________  Date: __________________________

MAIL COMPLETED FORM PROMPTLY TO PENN STATE WORKERS’ COMPENSATION, 410 JAMES M. ELLIOTT BUILDING, UNIVERSITY PARK, PA 16802.

For Workers’ Compensation Use Only:

Claim Number ______________________________
To All Employees:

The Workers’ Compensation law provides some replacement wages and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Employers are required to post the name of the company responsible for paying workers’ compensation benefits in a prominent and easily accessible place; including areas used for the treatment of injured employees or for the administration of first aid. Penn State’s Workers’ Compensation coverage is provided through the Sedgwick.

You should report immediately any injury or work-related illness to your supervisor or human resources representative. Your benefits could be delayed or denied if you do not notify your supervisor or human resources representative immediately.

If your claim is denied by Sedgwick, then you have the right to request a hearing before a Workers’ Compensation Judge.

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 No. within Pennsylvania: 800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY – 800-362-4228 (for hearing and speech impaired only)
[www.state.pa.us](http://www.state.pa.us), pa keyword: workers’ comp.

In addition you can contact your human resources representative or the University’s Workers’ Compensation Office (814-865-0424) if you have any questions about Penn State’s policies.

Also attached to this sheet is a complete list of panel physicians and medical providers for your reference.

EMPLOYEE SIGNATURE: _________________________________________ DATE: ______________

EMPLOYEE NAME (PRINTED): ____________________________________

EMPLOYER REPRESENTATIVE: ___________________________________ DATE: ______________
INCIDENT INVESTIGATION FORM

Directions for Completion:
1. Notify OPP H&S specialist within 24 hours of incident (Employee Injury, Near Hit, Property Damage).
2. Complete and submit this form to the OPP Safety Office within 3 working days of the accident/incident.
3. Please remember to sign and date the form.
4. Make five copies of this form for any Lost Time Injury Investigations.

Employee’s Name: ____________________________
Department: ____________________________
Work Group/District: ____________________________
How long have you been employed at OPP: ____________________________
Location of accident (Building, Room Number): ____________________________
Date of accident: ____________________________
Time of accident: ____________________________ AM PM (choose)
Supervisor Name: ____________________________
Signature: ____________________________

Accident Data/Contributing Factors

Detailed narrative of how incident occurred:

Description of Pictures Taken:

What was employee doing just prior to accident (job task, include any tools or machinery used):

Body part injured and type of injury (be specific):
If it is a Near Hit, describe the potential injury/damage:

Weather conditions at time of accident:

Visibility/Lighting (ex. poor, work lights, etc.):

Type and condition of floor surface (ex. concrete, wet):

PPE required for job:

Was PPE being utilized? □ Yes □ No

Was there any damage to property or equipment? □ Yes □ No

Explain:

Name(s) of witness(es): ____________________________ Phone#
Name(s) of witness(es): ____________________________ Phone#
### Causes

**PLEASE CHECK ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS**

<table>
<thead>
<tr>
<th>Direct/ Immediate Causes (supervisor complete)</th>
<th>Root Causes</th>
<th>Corrective Actions</th>
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<td>Employee unaware of hazard</td>
<td>Recommended Engineering control, Training, or Program/policy change:</td>
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<td>Not employees normal job</td>
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### Corrective Actions

**Recommended Engineering control, Training, or Program/policy change:**


**Remedial training given:**


**Was a work order or a project request submitted for solution(s)?**

*Please provide details of request including job/project number and deadline for completion:*


**What action was or should be taken to prevent recurrence?**


**Corrective actions completed?**  Yes  No

**If no, explain:**


**Investigated by:** ___________________________  **Date:** ________________

**Reviewed by:** ___________________________  **Date:** ________________

TSS/2-10