Send copy to the Human Resource Department **within** 24 hours.

Marywood UNIVERSITY

Injury /Illness Incident Report

For HR Use Only
CLAIM #:

Employment Status (please check one): ☐FT ☐PT ☐ Other

Building: _____

SEE BACK OF THIS FORM FOR SPECIFIC DESCRIPTIONS FOR USE IN FILLING OUT INCIDENT REPORT

INJURED EMPLOYEE: FIRST	MIDDLE	LAST	TODAY'S DATE

ADDRESS INCLUDING ZIP CODE	COUNTY	EMPLOYEE PHONE NUMBER (Include Area Code)

DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE ☐ FEMALE ☐	MARRIED: YES NO DEPENDENTS: ___	DATE HIRED	START TIME ☐ AM ☐ PM	NORMAL WORKING DAYS ☐ SAT ☐ SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI	SHIFT

JOB TITLE	DEPARTMENT	IMMEDIATE SUPERVISOR PHONE:	LENGTH OF CURRENT TIME ON THIS JOB: ☐ Less than 30 days ☐ Less than 90 days ☐ 1 to 5 years ☐ More than 5 years ☐ Less than one year	DATE OF HIRE:

DATE INCIDENT REPORTED	INCIDENT DATE & TIME	LOCATION WHERE INCIDENT OCCURRED

DID THE EMPLOYEE RECEIVE FIRST AID?	WAS EMPLOYEE SENT OFF-SITE FOR MEDICAL CARE? ☐ NO ☐ YES, WHERE?	WITNESS (NAME AND PHONE #)

NATURE OF INJURY / ILLNESS (i.e. cut, bruise, scratch, rash, multiple injuries, pain, etc.)

BODY PART INJURED (i.e. head, eye, face, arm, hand, elbow, shoulder, back, leg, foot, knee, etc.) Specify left/right, upper/lower, which finger(s), toe(s).

DESCRIBE IN EMPLOYEE'S OWN WORDS–WHAT WAS EMPLOYEE DOING WHEN INJURED? (BE SPECIFIC, IF USING TOOLS, EQUIPMENT, OR HANDLING MATERIAL – NAME THEM AND TELL WHAT HE WAS DOING WITH THEM.)

DESCRIBE IN EMPLOYEE'S OWN WORDS – 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 ANY SAFETY OR WORK RULES VIOLATED: YES NO DESCRIBE:	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES NO WERE THEY USED? YES NO

DOES INJURY REQUIRE ANY TIME OFF? YES NO
IF YES, DATE DISABILITY BEGAN:

WHAT ACTION HAS BEEN TAKEN TO PREVENT RECURRENCE?

WORKERS COMP NOTIFICATION SIGNED? YES NO	LIST OF PROVIDERS GIVEN? YES NO	MEDICAL AUTHORIZATION FORM GIVEN? YES NO	PHYSICIAN MEDICAL FORM GIVEN? YES NO	PRESCRIPTION INFO SHEET GIVEN? YES NO	

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

FOR HR USE ONLY ☐Non-Work Related

RECEIVED IN HR (Date):

Part B

Marywood UNIVERSITY

INVESTIGATION REPORT

(All Incidents should be investigated)

For HR Use Only
Incident Report Number

FACILITY:	DEPARTMENT:	DATE OF INCIDENT:
NAME:	LOCATION:	TODAY'S DATE:

1. Source Check (✓) object or substance most closely associated with the incident. At least one check (✓) MUST be entered in this section.

☐ 1.1 Machines/Machinery	☐ 1.6 Power Equipment/Forklift	☐ 1.11 Material / Product
☐ 1.2 Hoisting Apparatus	☐ 1.7 Hand Tools	☐ 1.12 Working/Walking Surfaces
☐ 1.3 Conveyors	☐ 1.8 Chemicals	☐ 1.13. Elevators
☐ 1.4 Boilers & Pressure Vessels	☐ 1.9 Vehicles	☐ 1.14 Radiations/Ultraviolet
☐ 1.5 Highly Inflammable & Hot Substances	☐ 1.10 Dusts	☐ 1.15 Other, Explain

2. Contacts One check (✓) MUST be entered in this section

☐ 2.1 Striking Against	☐ 2.5 Fall to Different Level	☐ 2.9 Contact with Electric Current
☐ 2.2 Struck By	☐ 2.6 Over-Exertion/Strain	☐ 2.10 Foreign Bodies
☐ 2.3 Caught In, On or Between	☐ 2.7 Exposure - i.e. - Chemicals, Heat Cold	☐ 2.11 Other, Explain
☐ 2.4 Fall on Same Level	☐ 2.8 Cumulative/Repetitive	

Describe how the event occurred, including any objects or substances involved and tell how they were involved:

IMMEDIATE CAUSES

3. Substandard Acts At least one check (✓) MUST be entered in this section.

☐ 3.1 Operating Without Authority ☐ 3.2 Failure to Warn	☐ 3.9 Removing/disconnecting or making safety devices inoperable	☐ 3.17 Failure to follow safety rule #_____
☐ 3.3 Failure to secure	☐ 3.10 Improper/unsafe loading	☐ 3.18 Failure to recognize hazards
☐ 3.4 Operating/working at unsafe speed	☐ 3.11 Improper/unsafe placement	☐ 3.19 Long Reach
☐ 3.5 Failure to follow procedures	☐ 3.12 Improper/unsafe lifting	☐ 3.20 Using hand as hammer
☐ 3.6 Using defective equipment	☐ 3.13 Improper/unsafe position for task	☐ 3.21 Bending or twisting
☐ 3.7 Using equipment improperly/unsafely	☐ 3.14 Horseplay	☐ 3.16 Other, Explain -
☐ 3.8 Failure to use PPE properly	☐ 3.15 Servicing equipment in operation or placing body part in moving equipment	

4. Substandard Conditions At least one check (✓) MUST be entered in this section.

☐ 4.1 Inadequate guards or barriers	☐ 4.7 Environmental hazards	☐ 4.14 Sharp work edge
☐ 4.2 Inadequate or improper PPE/ dress/apparel hazards	☐ 4.8 Noise Exposure ☐ 4.9 Inadequate Ventilation	☐ 4. 15 High/low work surface ☐ 4.16 Lifting above shoulder
☐ 4.3 Inadequate/improper/defective tools, equipment or materials	☐ 4.10 Inadequate or excess illumination	☐ 4.17 Lifting below knees ☐ 4.18 Reaching to side long
☐ 4.4 Congestion or restricted action ☐ 4.5 Inadequate warning system	☐ 4.11 High or low temperature exposure	☐ 4.12 Other: Explain -
☐ 4.6 Inadequate/poor housekeeping	☐ 4.13 Inadequate/improper layout	

Describe how the Substandard Acts/Conditions Caused the Event?

RECEIVED IN HR_____

BASIC CAUSES

5. Personal Factor At least one check (✓) MUST be entered in this section.

☐ 5.1 Lack of Knowledge	☐ 5.3 Improper Motivation	☐ 5.6 Unaware of surroundings
☐ 5.2 Lack of Skill/experience	☐ 5.4 Inadequate Capability/ preexisting conditions	☐ 5.5 Other, Explain

6. Job Factors At least one check (✓) MUST be entered in this section.

☐ 6.1 Inadequate Leadership/ Supervision/Team mentoring	☐ 6.4 Inadequate Maintenance	☐ 6.7 Wear and Tear
☐ 6.2 Inadequate Engineering	☐ 6.5 Inadequate Tools & Equipment	☐ 6.8 Abuse or Misuse
☐ 6.3 Inadequate Purchasing	☐ 6.6 Inadequate Work Procedure	☐ 6.9 Other, Explain

Describe how the Personal/Job Factors Caused or Could Cause this Event?

7. Action Plan Check (✓) corrective actions taken to prevent recurrence or reduce risk.

Inadequate/Lack of Program/Procedure/Process	Inadequate Standards/ Measurements/Training Program	Inadequate Compliance Program/Procedure/Process/Standard
☐ 7.1 Develop Procedures	☐ 7.2 Improve Procedures	☐ 7.3 Improve Compliance with Procedures
☐ 7.4 Write Job Task Analysis	☐ 7.5 Revise Current JTA	☐ 7.14 Employee read/reviewed JTA
☐ 7.7 Install Guard or Safety	☐ 7.8 Improve Design	☐ 7.6 Retrain/Reinstruct Individual
☐ 7.11 Post Signage	☐ 7.9 Improve Job Training	☐ 7.15 Retrain/Reinstruct Others – Tool Box
☐ 7.12 Improve Training -	☐ 7.10 Improve Housekeeping	☐ 7.13 Repair Defect
Fire extinguisher, First Aid	Work Order Issued on _____	Number _____

#	Corrective Actions To Prevent Recurrence Or Reduce Risk	Person Responsible For Action	Estimated Date of Completion	Date Completed

Number of incidents in previous 24 months Behavioral: _____ Cumulative: _____ Total: _____

Dates of Progressive Counseling Verbal: _____ Written: _____ Probation: _____ Separation: _____

Employee's Signature: _____ Date: _____

Safety Coordinator's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Department Manager's Signature: _____ Date: _____

MARYWOOD UNIVERSITY
INJURED EMPLOYEE MEDICAL REPORT

Employee's Full Name_____
Social Security Number_____ Phone_____
Date of Injury_____

Physician Name_____
Date Seen by Physician_____

Initial Examination at: (check one)
☐ Northeast Occupational Medicine ☐ Moses Taylor Hospital ☐ Other

If initially seen by other than Northeast Occupational Medicine (NEOM), please contact NEOM at 570-341-7777 to inform them of patient condition. Please inform patient that NEOM will contact him/her for follow up. Please contact Marywood University Human Resources at 570-348-6220 with patient status.

TO BE COMPLETED BY PHYSICIAN OR PRACTITIONER:

1. Subjective Complaints:

2. Physical Findings

3. Diagnosis:

4. Action Plan:

Return to Work for (check one) ☐ Regular Duty ☐ Transitional Duty for period from _____ to _____

Work Capacity:

☐ Lifting up to ___ pounds	☐ Sitting___hours	☐ Sedentary work only
☐ Pushing/pulling up to ___ pounds	☐ Standing___hours	☐ Operation of motor vehicle
☐ Bending/twisting ☐ yes ☐ no	☐ Climbing ☐ yes ☐ no	☐ Work on/near machinery
☐ Repetitive wrist movement ☐ yes ☐ no	☐ No Overtime on LT Duty	

☐ No Work Until_____

Physician Signature_____ Date_____

I fully understand my medical instructions and have been given a copy of this form to return to Marywood University.

Employee Signature_____ Date_____

MARYWOOD UNIVERSITY

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim, the payment of benefits or the administration of the insurance program under which the claim has been made. Your acceptance of benefits shall be considered an acceptance of the terms in this medical authorization, unless you indicate to the contrary in writing. Your decision not to authorize the release of any of the information described in this document does not eliminate any right that PMA or any other entity may have, under state and federal law, to obtain or disclose the information without an authorization. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to The PMA Insurance Group, P.O. Box 25249, Lehigh Valley, Pennsylvania, 18002, otherwise this authorization will continue to be valid.

Authorization to Release Medical Information

I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts, and any hospital, including the Veteran's Administration, or medical transportation company, to release to any of the PMA Insurance Group of Companies (including the PMA Insurance Company and PMA Management Corporation), and their subsidiaries, affiliates, representatives and agents (collectively, PMA), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim. This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems.

I authorize PMA, my Employer, and their representatives and agents to communicate directly both orally and in writing with all treating physicians or medical providers of any kind regarding all facts and opinions relevant to my workers' compensation claim. I authorize any treating physician or other medical provider to communicate directly both orally and in writing with PMA, my Employer, and their representatives and agents, concerning all aspects of my treatment for the illness or injury for which I am receiving or seeking benefits.

I also authorize the Social Security Administration to release to PMA information concerning entitlement dates and benefit amounts for myself.

I further authorize PMA to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-fraud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that PMA considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand the information released to PMA as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for twenty-four (24) months from the date listed below. A copy of this authorization is to be considered as valid as the original.

Employee Signature _____ **Date**_____

Employee Name _____

NOTICE TO EMPLOYEES

Your employer has provided for the payment of benefits under the Workers' Compensation Act of this State

IN CASE OF WORK-RELATED INJURY

- 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 prostheses, including training in their use.
- In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must immediately advise your supervisor of your injury, and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

DESIGNATED PHYSICIANS
(including address, telephone number, and area of medical specialty)

CLINICS

Northeastern Occupational Medicine
Occupational Medicine Clinic
769 Keystone Industrial Park
Scranton, PA 18512
570-341-7777

Workmed
Occupational Medicine Clinic
235 Main St
Dickson City, PA 18519
570-383-9011

PHYSICIANS/SPECIALISTS

Brown, Stephen F., DC
Brown Chiropractic
Chiropratic Medicine
1767 Quincy Ave
Scranton, PA 18509
570-341-5544

St Joseph's Center
Physical Therapy
2010 Adams Ave
Scranton, PA 18509
570-342-8379

Dhaduk, Vithalbhai D., MD
Professional Neurological Assoc, PC
Neurology
121 S Apple St
Scranton, PA 18512
570-963-8803

Dodge, Nicholas D., MD
Internal Medicine
1401 Electric St
Dunmore, PA 18509
570-344-5115

Michael Wolk MD
Northeastern Rehab Associates
Physical Medicine/ Rehabilitation
5 Morgan Highway
Scranton, PA 18508
570 344 3788

Sollman, Joseph S., MD
Internal Medicine
2324 Boulevard Ave
Scranton, PA 18509
570-343-2244

Christopher Metzger, MD
Scranton Orthopaedic Specialists PC
Orthopaedic
334 Main St.
Dickson City, PA
570 307 1767

TMESYS Pharmacy Program - To contact your local TMESYS Pharmacy, please call (800) 964-2531

- You must continue to visit one of these persons listed above, if you need treatment, for ninety (90) day from the date of your first visit. If you do not, your employer may not be required to pay these services.
- After this ninety (90) day period, if you still need treatment and your employer had provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice, or your employer may not be required to pay for these services.
- Your bills will be paid for IF: your licensed physician or practitioner of the healing arts files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.
- If no list is provided as above, you may go to a licensed physician of practitioner of the healing arts of your choice.
- If one of the persons listed above refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.
- If you are faced with a medical emergency, you may secure assistance from a hospital or physician or practitioner of the healing arts of your choice.

Name: Marywood University **Address:** 2300 Adams Ave Scranton, PA 18509 5373329 **Generated:** 11/19/2009

Radius: 0 mile(s)

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

PMA Newly Injured Worker Prescription Information Sheet *TAKE TO PHARMACY*

Injured Worker Name:_____ **Social Security #:**_____ **Date Of Injury:**_____

Dear Injured Worker,

*On your first visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Worker's Compensation prescriptions. based on the established parameters by **PMA.***

Dear Pharmacist,

Please call Tmesys to obtain the ID # necessary to process the medications for this injured worker. Your company has signed an Agreement to participate in the *Tmesys™* Workers' Compensation Pharmacy PPO. If you do not find us in your computer or your plan book, please call Tmesys™ immediately at 800-964-2531. Thank you for your assistance.

Sincerely,

***Tmesys™*, Inc.**

ALL PARTICIPATING PHARMACIES HAVE NOT BEEN INCLUDED ON THIS LIST. PLEASE CALL TMESYS REGARDING ANY QUESTIONS (800) 964-2531

CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME
A & P	index: TYS	Happy Harry's	index:TME	Pic & Save	plan name: T or TMESYS	Tri Daly Drugs	Carrier code: TMS
Arbor Drug	Carrier code: TI	Harco Phcy	index: TYS	Prevo Drugs	input code: TS	Turner Drugs	Index: Tmesys
Bartell Drug	Index: TMS	Hi-School Pharmacy	TMESYS Central Billing code:TM01	Publix	carrier:TME plan: SYS or TYS	Twin Value	carrier code:TYS
Big B	index: TYS	HEB Phcy	price code:T9	Raley's/Bel Air Phcy	plan: Tmesys	U-Save	index: TME
Biggs	Carrier code: TYS	Hooks, Brooks& Super X(HIS)	index: TME	Randalls Pharmacy	TMSRX	United	TYS
Bi-Lo Pharmacy	input code: TMS	Horizon Pharmacy	TYS	Revco drugs	TMWC	Vons	carrier: TME
Bi-Mart	index: TMESYS	HyVee Drugtown	index:bin # in 3rd party set up	Rite-Aid drugs	TMESYS	VIX Pharmcay	carrier code: TME
Brooks Drugs	Code: TME	J & J Pharmacy	TCS	RX Discount Pharmacy	input code:TME	Walgreens	carrier code: TMEWC
Brookshire Brothers	Condor Code: 2050	Joel & Jerry's	index: TME	Sack-n-Save	plan#: 6012 or 5097	Wal-Mart phcy	carrier: TME
Cardinal Health	index: Call support	K & B	Plan code:TMESYS	Safeway Phcy	processor code: TME or TYS	Wegman Pharmacy	carrier code: TME
Cub Pharmacy	Carrier Code: TYS	Kash N Karry	plan: TYS	Sav-A-Lot	60	Weis Markets	carrier code: TYS
CVS Drugs	Condor Code: 8822	Kerr Drugs	TMESYS	Sams Club Pharmacy	carrier code: TME	Winn-Dixie	index: TME (plan 2066)
Drug Emporium	TYS	K-mart phcy	Carrier code: TYS	Save Mart	Carrier code: TYS		
Drug Fair	index: TMESYS	Kroger Phcy	index: TS,TM,YS	Shopko Pharmacy	TYS		
Duane Reade	TMESYS	Laverdiere's	plan name: TMESYS	Shop N Save	carrier code: TYS		
Eckerds(FL)	Terminal plan:2802(FL)	Lifecheck Drug	TMESYS	Shop-Rite	TYS		
Eckerds(all others)	Terminal plan:2801	Long's Phcy	plan: #1,TMES	Stop N Shop	146		
Franck's Pharmacy	price code: TM	Medicine Shoppe	varies by each store system	Super D	Plan name:332		
Fred Meyer	TYS	Medstat Phcy	Condor code: 2425	Super Valu	carrier code: TYS		
Fred's Pharmacy	TMESYS	Milner-Rushing Drugs	compensation as Tom Ashley	Super X (HSI)	index: TME		
Genovese	Now Eckerd Drugs!	National Supermarkets	use "Separate Plan Number"	Target Pharmacy	index: TYS		
Giant Eagle Pharmacy	index:TME (Do not use WC plan	NOB Hill Phcy	plan: TMESYS	Thrift Drug	carrier code: 4139		
Giant Pharmacy	TMESYS	Pathmark Pharmacy	TYS	Thriftway Pharmacy	2066		
Goodings	TME index D, bill code TME	Perry Drg Str	index:TS	Tom Thumb Phcy	pdx code: TMS		
Hannaford Food & Drug	index: TYS	Phar-Mor	TYS	Tops Pharmacy	access code: TI		

***ALL PARTICIPATING PHARMACIES HAVE NOT BEEN INCLUDED ON THIS LIST. PLEASE HAVE YOUR PHARMACY CALL TMESYS REGARDING ANY QUESTIONS/AUTHORIZATIONS**

(800) 964-2531.

PMA Newly Injured Worker Prescription Information Sheet *TAKE TO PHARMACY*

Injured Worker Name:_____ **Social Security #:**_____ **Date Of Injury:**_____

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Sincerely,

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CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME	CHAIN NAME	INDEX NAME
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Arbor Drug	Carrier code: TI	Harco Phcy	index: TYS	Prevo Drugs	input code: TS	Turner Drugs	Index: Tmesys
Bartell Drug	Index: TMS	Hi-School Pharmacy	TMESYS Central Billing code:TM01	Publix	carrier:TME plan: SYS or TYS	Twin Value	carrier code:TYS
Big B	index: TYS	HEB Phcy	price code:T9	Raley's/Bel Air Phcy	plan: Tmesys	U-Save	index: TME
Biggs	Carrier code: TYS	Hooks, Brooks& Super X(HIS)	index: TME	Randalls Pharmacy	TMSRX	United	TYS
Bi-Lo Pharmacy	input code: TMS	Horizon Pharmacy	TYS	Revco drugs	TMWC	Vons	carrier: TME
Bi-Mart	index: TMESYS	HyVee Drugtown	index:bin # in 3rd party set up	Rite-Aid drugs	TMESYS	VIX Pharmcay	carrier code: TME
Brooks Drugs	Code: TME	J & J Pharmacy	TCS	RX Discount Pharmacy	input code:TME	Walgreens	carrier code: TMEWC
Brookshire Brothers	Condor Code: 2050	Joel & Jerry's	index: TME	Sack-n-Save	plan#: 6012 or 5097	Wal-Mart phcy	carrier: TME
Cardinal Health	index: Call support	K & B	Plan code:TMESYS	Safeway Phcy	processor code: TME or TYS	Wegman Pharmacy	carrier code: TME
Cub Pharmacy	Carrier Code: TYS	Kash N Karry	plan: TYS	Sav-A-Lot	60	Weis Markets	carrier code: TYS
CVS Drugs	Condor Code: 8822	Kerr Drugs	TMESYS	Sams Club Pharmacy	carrier code: TME	Winn-Dixie	index: TME (plan 2066)
Drug Emporium	TYS	K-mart phcy	Carrier code: TYS	Save Mart	Carrier code: TYS		
Drug Fair	index: TMESYS	Kroger Phcy	index: TS,TM,YS	Shopko Pharmacy	TYS		
Duane Reade	TMESYS	Laverdiere's	plan name: TMESYS	Shop N Save	carrier code: TYS		
Eckerds(FL)	Terminal plan:2802(FL)	Lifecheck Drug	TMESYS	Shop-Rite	TYS		
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Genovese	Now Eckerd Drugs!	National Supermarkets	use "Separate Plan Number"	Target Pharmacy	index: TYS		
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Giant Pharmacy	TMESYS	Pathmark Pharmacy	TYS	Thriftway Pharmacy	2066		
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Hannaford Food & Drug	index: TYS	Phar-Mor	TYS	Tops Pharmacy	access code: TI		

***ALL PARTICIPATING PHARMACIES HAVE NOT BEEN INCLUDED ON THIS LIST. PLEASE HAVE YOUR PHARMACY CALL TMESYS REGARDING ANY QUESTIONS/AUTHORIZATIONS**

(800) 964-2531.

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** _____