DREXEL UNIVERSITY
COLLEGE OF MEDICINE

Risk Management
1601 Cherry Street, Suite 10627
Philadelphia, PA 19102
Phone (215)255-7838
Fax (215)255-7856

Employee Incident Report For Work-Related Injuries

(All 3 pages of this form must be completed and faxed by employee and/or supervisor to Risk Management at 215-255-7856. It is the responsibility of the employee to report their injury to Risk Management. Failure to report an injury may result in denial of claim.)

SECTION 1 EMPLOYEE INFORMATION

Injured Employee Name: _____ Department: _____

Job Title: _____ Normal Work Location: (Bldg, Room #) _____

Social Security No.: _____ Date of Birth: _____ (Day/Month/Year) Marital Status: ☐ S ☐ M Sex: ☐ M ☐ F

Employment: ☐ Full Time ☐ Part Time Work Schedule: (ex: M-F, 8:00 a.m. - 5:00 p.m.) _____

Name of Direct Supervisor: _____ Supervisor Phone Number: _____

Work Phone: _____ Home Phone: _____ Email: _____

Home Address: _____
Street City State Zip

SECTION 2 INJURY INFORMATION

Date of Injury: _____ (Day/Month/Year) Time of Injury: _____ a.m. p.m. (circle) Date injury reported: _____ (Day/Month/Year)

Reported to whom? _____ Title _____ Phone: _____

Has employee missed days from work? ☐ Yes ☐ No If yes, dates missed: _____

Date returned to work: _____

How did injury occur: (Describe in detail what employee was doing at time of injury and how it occurred

_____

_____

Nature and location of injury or disease: (specify part(s) of body and how affected) _____

_____

Name of Witness: _____ Department: _____ Phone: _____

SECTION 3 MEDICAL TREATMENT

Date of initial treatment: _____ (Day/Month/Year) Check here if there has been no medical treatment ☐

Medical provider: _____ Phone #:_____

Address: _____
Street City State Zip

Check here is treatment was provided by WorkNet at HUH ☐

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

Signature also required on pages 2 and 3.

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Workers' Compensation Information

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.

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.

You should report immediately any injury or work-related illness to your employer.

Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, 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 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.

I hereby acknowledge receipt of the "WORKERS' COMPENSATION INFORMATION" form.

_____ _____

Employee Name (Print) Supervisor Name (Print)

_____ _____

Employee Signature Supervisor Signature

Date _____

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NOTICE TO EMPLOYEE AND EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS AND RESPONSIBILITIES FOR WORK RELATED INJURIES

If you suffer a work related injury or illness, your employer or its workers' compensation insurance company must pay for medical and surgical services, services rendered by physicians or other health care providers, medicines and supplies, which are reasonable, necessary and related to the work related injury.

Your employer has posted in the work place at least six designated health care providers. In order to ensure that your reasonable and necessary medical treatment and supplies will be paid for by your employer or its workers' compensation insurance company during the first 90 days of treatment, you must select and visit one of the listed health care providers, and continue to visit that health care provider or another of the listed health care providers for a period of ninety (90) days from the date of the first visit. As required by law, this list will include no more than four (4) coordinated care organization (as approved by the state), and no fewer than three (3) physicians. You are permitted to switch from one health provider on the list to another health care provider on the list during the ninety (90) day period.

The employer is not permitted to include on this list a physician or health care provider who is employed, owned or controlled by your employer or its workers' compensation carrier unless that employment, ownership or control is disclosed on the list.

You have the right to seek treatment from a provider not appearing on the list (referral provider) if you are referred to such provider by one of the designated providers appearing on the list: Your employer shall pay for the reasonable and necessary treatment rendered by the referral provider for the work related injury.

You have the right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be rendered by a designated provider for the remainder of the ninety (90) day period.

If one of the designated providers prescribes or recommends invasive surgery, you may seek and receive an additional opinion from any health care provider of your own choice. The charge for this consultation will be paid by your employer or its workers' compensation insurance carrier. If the additional opinion differs from the opinion provided by the designated provider, you may choose which course of treatment to follow: provided; however, that the second opinion includes a specific and detailed course of treatment. If you choose to follow the providers designated in the additional or second opinion, such procedures shall be performed by one of the designated providers for a period of ninety (90) days from the date of your visit to the physician rendering the second additional opinion.

With regard to, all other treatment (i.e. that not involving invasive surgery) you have the right to seek treatment or medical consultation from a non-designated provider during the ninety (90) day period, but such services shall be at your own expense during the applicable period of ninety (90) days.

Following the first ninety (90) days of treatment with the designated physician or other health care provider, subsequent treatment may be provided by any health care practitioner of your own choice. You must notify your employer that your care has been transferred to a non-designated provider within five (5) days of your first visit to the non-designated provider of your choice. Your employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a Utilization Review Organization.

I, _____ hereby acknowledge that I have received this notice, and that I understand my rights and responsibilities as set forth by Drexel University College of Medicine.

Signature of Employee: _____ Date