Procedure: **Workplace Illness and Injury Reporting**
Policy number: **HRM-121P**
Effective date: **September 2011**
Next review date: **July 2012**
Review officer: **Chief Human Resources Officer**

1. Purpose

The following procedures, which are in accordance with applicable laws are provided to assist employees in reporting work-related injury or illness to ensure compliance with state regulations and university policy.

2. Employees

2.1 Life Threatening Medical Emergencies - injuries or illnesses that need immediate medical care.

A. If an employee is faced with a medical emergency, he/she or a co-worker may call 911 for emergency medical treatment to dispatch; or

B. Go to the closest emergency room; and

C. Contact Risk Management at 484.365.7595 for directory information on designated health care provider for follow-up care to emergency treatment as soon as reasonably possible.

2.2 Non-life Threatening Injuries or Illnesses. The following procedure must be followed in case of work related injury or illness.

A. Injured worker must report the workplace injury to his/her supervisor as soon as possible, within one business day; and

B. Complete the *Employee Questionnaire; Injury/Disease Report; Authorization for Disclosure of Health Information and/or Medical Treatment Waiver Form* and bring report to Risk Management in the Office of Human Resources (Attachment I).

C. Meet with Risk Management to review documents and file a claim for workers' compensation.

D. For employees who experience a workplace injury or illness at work post-accident drug testing is required within 24 hours of the injury or onset of illness. The Risk Management Specialist in the Office of Human Resources shall provide the employee with appropriate form for such testing at Quest Diagnostics (800-377-8448).

E. An employees' failure to report a workplace injury or illness within policy guidelines may result in disciplinary action up to termination of employment.

3. Supervisors

3.1 Perform accident investigation to determine root cause(s) associated with the injury or illness and take photos as required and report findings within 24 hours of accident/injury.

3.2 Implement corrective action to reduce the loss exposure / risk of injury and to prevent future unsafe work practices, as necessary and/or as recommended by the safety committee.

3.3 Implement progressive disciplinary action, if root cause is determined to be the result of the employee's engagement in unsafe work practices for which the employee has been trained and such training is documented.

3.4 A supervisor's failure to report a workplace injury or illness within policy guidelines may result in disciplinary action up to termination of employment.

4. Office of Human Resources – Risk Management

4.1 Provide the employee with the following documents and information:

A. *Notice to Employees* and list of *Designated Physicians* (Attachment II); this notice is also posted in the Office of Human Resources and at all time clocks;

B. Inform employee of his/her rights under the Pennsylvania Workers' Compensation Act (or other state law as applicable) and ask employee to complete *Employee Acknowledgement of Rights and Responsibilities* under Pennsylvania Workers' Compensation Act (Attachment III);

4.2 Report injury or illness to the University's Workers' Compensation insurance carrier.

4.3 Provide notice to the employee's supervisor regarding the individual's status and/or restrictions, next appointment, and treatments as provided by physician.

4.4 Provide notice to payroll to ensure employee is compensated for reasonable time spent at doctors and treatment appointments.

4.5 Perform root cause analysis and report accident findings to safety committee to determine recommended corrective action to reduce future loss exposure.

4.6 Monitor records with the insurance carrier regarding employee status, treatment, restrictions, appointments, etc.

Questions about this policy may be addressed to:
Lincoln University - Office of Human Resources
1570 Baltimore Pike
Lincoln University, PA 19352
484-365-8059

Attachment I

HM INSURANCE GROUP
A HIGHMARK COMPANY
HM WORKERS' COMPENSATION

P.O. Box 2738
Pittsburgh, PA 15230
Phone: 800-880-7963
Fax: 800-749-9826
www.HMWorkersComp.com

WORKERS' COMPENSATION EMPLOYEE QUESTIONNAIRE

EMPLOYEE INFORMATION

Name	Home Phone
Address	Cell Phone
City	State / Zip
Date of Birth	Social Security Number
Do you currently have a driver's license? ☐ Yes ☐ No	Occupation_____ ☐ Full-time ☐ Part-time

Briefly describe your job duties:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Number of Dependents
Weight	Height

Are you ☐ Left-handed ☐ Right-handed?

Do you participate in any sports, hobbies and/or recreational activities? ☐ Yes ☐ No If yes, please list below:

_____

_____

_____

Primary Care Physician Name	Primary Care Physician Phone

Have you reported any Workers' Compensation claims in the past? ☐ Yes ☐ No
If yes, please provide the approximant injury date(s), diagnosis and body part(s) injured:

_____

_____

_____

Please list your past medical history, including non-work-related injuries, motor vehicle accidents, chronic illnesses and previous surgeries. Please include names of treating physicians:

_____

_____

_____

WORK / INJURY INFORMATION

Name(s) of Current Employer(s)

Phone Number(s) of Current Employer(s)

Injury Date	Time Shift Started
Time of Injury	Date Injury Was Reported to Employer

Person To Whom Injury Was Reported

Describe How Your Work Injury Occurred:

Were there any witnesses to your work injury? ☐ Yes ☐ No If yes, please list below:

Last Name	First Name		
Address	City	State	Zip
Home Telephone	Work Telephone	Job Title	
Last Name	First Name		
Address	City	State	Zip
Home Telephone	Work Telephone	Job Title	

MEDICAL INFORMATION

Provide date(s) of onset of current medical problem(s) and symptoms:

List body parts injured:

For all medical treatment and diagnostic testing, please list the date(s) of service and provider name(s):

Please indicate the date of your next medical appointment and the physician's name:

What are your current complaints?

Have you had prior problems or treated with a medical provider for this body part in the past? ☐ Yes ☐ No If yes, explain below:

For all prior medical treatment, please list the date(s) of service and provider name(s):

WORK STATUS INFORMATION

Have you been medically released to return to work for this injury? ☐ Yes ☐ No If yes, please provide your date of release:

Were you released to ☐ Full duty ☐ Modified duty?

Have you returned to work according to your medical release? ☐ Yes ☐ No
If yes, please provide the date of your return:
If no, please indicate why you have not returned:

FRAUD NOTICE

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature

Date

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WORKERS' COMPENSATION OCCUPATIONAL INJURY/DISEASE REPORT

Company Name _____
Location _____
Department _____
Policy Number _____

Print in blue or black ink.

EMPLOYEE INFORMATION

Last Name	First Name		☐ Male ☐ Female
Home Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Date of Birth	
Social Security No.	Marital Status ☐ Single ☐ Married ☐ Other	Hire Date	Job Classification
Job Title	☐ Full-time ☐ Part-time / ☐ Salaried ☐ Hourly	Start time	Jurisdiction State
Work Address	City	State	ZIP Code

ACCIDENT DETAILS (Attach additional pages if necessary)

Date	Time ☐ AM ☐ PM	Date employee reported accident
Place of accident		
Loss Type ☐ Incident Only ☐ Medical Only ☐ Modified Duty ☐ Off Work		If off work, what was the first date
If the employee did miss work, has he/she returned to work? ☐ Yes ☐ No		If yes, date he/she returned to work
Type of Injury	Cause of Injury	
Body Part ☐ Left ☐ Right ☐ Unspecified		
Nature of injury (describe how the injury occurred)		

MEDICAL INFORMATION

Treating Physician

Last Name	First Name		Telephone Number
Address	City	State	ZIP Code

Family Physician			
Last Name	First Name		Telephone Number
Address	City	State	ZIP Code

External Medical Facility			
Organization Name			Telephone Number
Address	City	State	ZIP Code

WITNESS(ES) TO ACCIDENT (Attach additional pages if necessary)			
Last Name	First Name		
Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Job Title	
Last Name	First Name		
Address	City	State	ZIP Code
Home Telephone Number	Work Telephone Number	Job Title	

REPORT SUBMITTED BY	
Name	Date
Job Title	Work Telephone

INFORMATION RECEIVED BY		
Signature	Date	Time

FRAUD NOTICE

In New Jersey, any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

In Pennsylvania, 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.

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WORKERS' COMPENSATION AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

(1) I hereby authorize_____ to release/disclose the following information of:
(Name of Releaser – e.g., HM Life Insurance Company, HM Life Insurance Company of New York, or other entity)

Patient/Member Name	Date of Birth
Address	
Identification Number	Telephone

The records to be disclosed cover the following period(s):

From _____ to _____
(Date) (Date)

From _____ to _____
(Date) (Date)

(2) ☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must ***not*** use it as an authorization for any other type of protected health information.

(3) Information to be disclosed (Please check only that which applies.):

Designated Record Set: (Please check only that which applies.)

☒ Enrollment Information ☒ Claims Information ☒ Payment Information

☒ Managed Care Information (Precertification, 2nd Opinions, Treatment Plans, Care Coordination, Case Management, etc.)

AND/OR

☒ Pharmaceutical information ☒ Discharge summary ☒ History and physical examination

☒ Consultation reports ☒ Progress notes ☒ Laboratory tests

☒ X-ray reports ☒ Explanation of Benefits ☒ Complete health record(s)

☐ Other (please specify)_____

I understand that this will include information relating to (check if applicable):

☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV)

☐ Mental health care ☐ Sexually transmitted disease

☐ Treatment for alcohol and/or drug abuse ☐ Other (please specify)_____

(4) This information is to be disclosed to _____
(organization or provider)

by Releaser for the purpose of _____.
(state purpose)

(5) I understand that I may revoke this authorization at any time by giving written notice of my revocation to _____. I understand that revocation of this authorization will *not* affect any action Releaser took in reliance on this authorization before it received my written notice of revocation. I also understand that without my written authorization, Releaser may not use or disclose my health information for any reason except those described in Releaser's Notice of Privacy Policies and Practices. Unless otherwise revoked, this authorization will expire on the following date, event or circumstance:
(insert date, event, or circumstance – if no date, event or circumstance is included, this Authorization will expire one year after date of member signature)

_____

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that Releaser may condition my enrollment or eligibility for benefits on my signing of this authorization (other than for psychotherapy notes), before Releaser enrolls me, to allow Releaser to obtain protected health information from another covered entity to determine my eligibility or enrollment or Releaser's underwriting or risk rating.

I understand that Releaser may condition payment of a claim for specified benefits on my signing of this authorization (other than for psychotherapy notes) to allow other covered entities to disclose protected health information to Releaser that Releaser needs to determine payment of my claim.

Releaser, its subsidiaries, affiliates, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signed (Patient/Member) Date

_____ _____
(Personal Representative) (Include a description of such representative's authority to act for the patient/member) Date

You are entitled to a copy of this authorization after you sign it.

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WORKERS' COMPENSATION MEDICAL TREATMENT WAIVER FORM

I decline to seek medical treatment for an incident that I reported as having occurred during the course and scope of my employment on _____.

My employer has provided me with their Workers' Compensation panel provider list from which injured employees must seek treatment for work related injuries requiring medical attention for a period of 90 days from the date of first visit.

I agree to notify my employer immediately should I choose to seek medical attention at a later date.

Employee Name: _____
Print Name

Employee Signature: _____ Date:_____
Signature

Employer: _____
Print

Witness Name: _____
Print Full Name

Witness Signature: _____ Date:_____
Signature

HM INSURANCE GROUP
A HIGHMARK COMPANY

HM WORKERS' COMPENSATION

Lincoln University
NOTICE TO EMPLOYEES

Your employer is insured under the Workers' Compensation Act of Pennsylvania.

In case of work-related injury or illness:

1 REPORT THE INJURY TO YOUR SUPERVISOR PROMPTLY
Failure to do so can delay your benefits or cause you to lose your rights to benefits.

2 OBTAIN MEDICAL CARE FROM THE DESIGNATED PHYSICIANS LISTED BELOW
You must treat with one of these panel providers for a period of 90 days.

Except in extreme emergency, if you go to a non-panel provider, the bills may not be covered by Workers' Compensation. If a panel provider refers you to another physician, bills will be covered.

If a panel provider recommends invasive surgery, you may obtain a second opinion from a non-panel provider at your employer's expense. If you elect to follow the treatment recommended by the non-panel provider, the treatment must be rendered by a panel provider for 90 days from the date of the visit to the non-panel provider.

After 90 days, you may go to a licensed practitioner of your choice if you still need medical care. Your bills will be paid if:

A. You notify the Claims Department about the new physician within five days of your first visit by calling 800-880-7963.

B. Your doctor files the required reports (first report within 10 days of commencing treatment, monthly reports thereafter).

DESIGNATED PHYSICIANS

You may select from one of the physicians or practitioners listed below:

Occupational Medicine

The Occupational Health Center
830 West Cypress Street
Kennett Square, PA 19345
(610) 610-738-2450
Or
915 Fern Hill Road
Building A, Suite 3
West Chester, PA 19380
(610) 738-2450

Family Practice

Robert F. Crowell, DO
1290 Baltimore Pike, Suite 104
Chadds Ford, PA 19317
(610) 459-3048

General Surgery

Nenito Uy, MD
3628 Lincoln Hwy
Thorndale, PA 19372
(610) 384-1303

Durable Medical Equipment Facility

Cypress Care
1-800-419-7191

United Medical Equipment
1-800-397-9900

Ophthalmology

James Carty, MD
1011 W Baltimore Pike, Suite 211
West Grove, PA 19390
(610) 869-0200

Lonnie Luscavage, MD
608 Chadds Ford Drive
Olworth Bldg, Suite 100
Chadds Ford, PA 19317
(610) 388-9755

Bruce Saran, MD
Bruce Stark, MD
915 Old Fern Hill Road
Building B, Suite 200
West Chester, PA 19380
(610) 696-1230

Neurology

Philip Adelman, MD
824 Main Street, Suite 302
Phoenixville, PA 19460
(610) 917-9551

Brian Kelly, MD
21 Industrial Blvd, Suite 205
Paoli, PA 19301
(610) 647-8000

Chiropractor

Matthew Duddy, DC
417 Pennsylvania Avenue
Avondale, PA 19311
(610) 268-8122

Jeffrey Klein, DC
821 West Chester Pike
West Chester, PA 19382
(610) 918-9455

Dr. David Shmukler
219 N Union Street
Kennett Square, PA 19348
(610) 925-0444

Physical Therapy

Premier Comp PT Network
Call Toll Free for Closest Location
1-888-594-4001

Novacare
1 Commerce Blvd., Suite 103
West Grove, PA 19390
(610) 345-0759

Pharmacy

Proceed to participating pharmacy with RX card, call 1-877-444-4644 if you need assistance or if you do not have a card.

Orthopedics

Smucker Orthopedics
900 West Baltimore Pike
West Grove, PA 19390
(610) 869-5757

Michael Maggitti, MD
460 Creamery Way, Suite 109
Exton, PA 19341
(610) 524-6580

Rothman Institute
1572 Wilmington Pike
Pioneer Urgent Care Center
West Chester, PA 19382
All Rothman Institute locations are available for scheduling
(267) 339-3776

Neurosurgery

Andrew Freese, MD
213 Reeceville Road, Suite 33
Coatesville, PA 19320
(610) 384-0482

Diagnostic Testing

One Call Medical
Call 1-866-626-7243 for locations and appointments.

800-880-7963 • HMWorkersComp.com

WORKERS' COMPENSATION

EMPLOYEE ACKNOWLEDGEMENT OF RIGHTS & RESPONSIBILITIES

Employer: Lincoln University

In Pennsylvania, 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 also acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306(f.1)(1)(I) of the Pennsylvania Workers' Compensation Act. My rights and duties include the following:

1. I recognize and agree that my employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). I further agree that my employer has provided the name, address, telephone number, and area of medical specialty of each designated provider on the list.

2. I have the duty to obtain treatment for work-related illnesses from one or more of the designated health care providers listed below for ninety (90) days from the date of first visit to a designated provider.

3. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.

4. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.

5. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.

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

7. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.

8. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.

9. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and,

10. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the procedure shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion).

I, _____, employee of

_____, hereby

certify that I was provided with the above statement and attached Provider Panel.

_____ _____

Employee Signature Date

_____ _____

Witness Signature Date