B R Y N M A W R C O L L E G E

Environmental Health & Safety

Report of Work-Related Injury or Illness

To be completed by the supervisor with the employee, if possible. Fill in as completely as you can, but do not delay submitting the report. Send to Environmental Health & Safety (EHS), Ward Bldg., within 24 hours. Report may be faxed to (610) 526-5220, with original following by campus mail. Questions? Call EHS at (610) 526-5166.

WHO: Employee's Name:_____

Address: _____ City:_____ State: _____ Zip Code: _____

Home phone no.: _____ Work phone ext.: _____ Date of Birth: _____

Student? [ ] Yes [ ] No Marital Status:_____ No. of children under 18:_____

[ ] Full time [ ] Part time Date of hire: _____ Regular starting time: _____

Department:_____ Job Title: _____

WHAT:

Part(s) of Body: _____ Type(s) of Injury: _____

(Examples: left ankle, lower back, etc.) (Examples: cut, sprain, fracture, burn, etc.)

Does Injury Require Medical Treatment? [ ] Yes [ ] No Any lost work days? [ ] Yes [ ] No

WHEN:

Date of Injury: _____ Time of Injury: _____AM/PM Date Reported to Employer:_____

WHERE: (Building name and room number, description of outdoor location where injury took place.)

_____

Name of treating facility: _____ (In case of emergency, go to nearest hospital emergency room. For non-emergencies or follow up care, call EHS at x5166 for assistance in arranging treatment from a designated workers' compensation medical care provider.)

HOW:

How did the injury occur? (Describe the events that resulted in the injury or illness. Tell what happened and how it happened. Name any tools, substances, or machinery or equipment involved.)

_____

_____

_____

Name(s) of witnesses: _____ Telephone:_____

EMPLOYEE AUTHORIZATION: I hereby authorize my attending physician to release any information or copies thereof acquired in the course of my examination or treatment for the condition reported above to my employer, Bryn Mawr College, its representative(s), and the College's workers' compensation insurance carrier.

Employee's signature: _____ Date: _____

Supervisor's printed name and signature: _____ Date:_____

EHS Use Only: PSN: _____

RO MTO RD LWDI DSB Date Filed: _____ Claim No. _____

Workers' Compensation Employee Notification

The Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider; however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for the first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another, and that treatment will be paid for by your employer.

If a designated health care provider refers your to another health care provider whose name is not on the list, your employer will pay for the treatment rendered by the provider to whom your where referred.

You have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended, but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days, in writing and with receipt acknowledged in writing by a Human Resources or Environmental Health and Safety staff member, of the first visit to that provider.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs form the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HERBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKERS' COMPENSATION ACT AS SET FORTH HEREIN.

_____	_____	_____
Employee name (print)	Employee signature	Date