

Appendix B

**College of Earth and Mineral Sciences Supervisor's Injury/Illness Investigation Report
available through your department office**

**Workers Compensation Employee Notification
<http://guru.psu.edu/gfug/instruct/4-03ex.pdf>**



College of Earth and Mineral Sciences
 SUPERVISOR'S INJURY/ILLNESS
 INVESTIGATION REPORT

Any Injury, no matter how minor in nature, must be reported immediately. This investigation is to be made by the Supervisor directly with the employee involved, and sent to the Earth and Mineral Sciences Safety Coordinator. (See back for instructions involving usage of terms.)

Department _____ Name of Supervisor _____ Office Phone _____

Employee's Social Security Number _____

Date Incident was Reported _____ Date of Injury and Time _____ Normal Starting Time _____
 AM PM AM PM

Employee Name: _____ M ___ Home Telephone Number _____
 F ___ University Telephone Number _____
 First Middle Last

Address: _____
 County Street City/Town State Zip

Married: Yes ___ No ___ Date of Birth _____ Age ___ Number of Children Under 18 _____

Job Title _____ Department _____ How Long Employed at PSU _____

DO NOT SUBMIT THIS FORM UNTIL THIS SECTION HAS BEEN FILLED OUT COMPLETELY BY SUPERVISOR

Place of Accident (Be specific) _____ Witnesses _____

What Was Employee Doing When Injured _____

How Did Injury Occur _____

Describe Fully Nature and Location of Injury (e.g., left hand burned, cut, bruised) _____

Attending Physician/Hospital & Address _____

This injury was a result of (check one or other categories):

___ Mechanical Defect/Hazardous Condition

Describe: _____

___ Unsafe Act/Carelessness

Describe: _____

Corrective action taken: _____

Will Lost Time Result: Yes ___ No ___

Supervisor's Signature

Date



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 the same for 90-days.

If additional or continued treatment is needed after the initial 90-day period, 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 who files an application for insurance or statement of claim containing any materially false information or conceals information for the purpose of misleading thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Your signature on this form indicates that you understand your rights and duties under the above provisions of the Workers' Compensation Act. Refusal to sign this notification does not relieve you of your requirement to treat with one of the panel physicians or health care providers as stated above.

I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act.

1	2
_____	_____
Print Name	Social Security No.
3	4
_____	_____
Employee Signature	Date