Boyertown Area School District

Human Resources

Workers' Compensation Employee Injury Packet

In the event of a medical emergency...seek medical attention immediately

Employee Responsibilities if Injured:

☐ **Report** injuries to your building leadership immediate after incident occurs

☐ **Injury Packets** can be found on the Boyertown Area School District website under "staff resources, human resource forms, Workers' compensation injury packet.

☐ **Select** a treating physician from the approved provider panel in this packet if treatment is needed

☐ **Sign and Return:**

"Employee Incident Report" (Pages 2 & 3)

"Rights and Duties Form" (Page 5)

"Medical Record Release Authorization" (Page 6)

Return to:

Cindi Bartholomew
Human Resources – Education Center
Email: cbartholomew@boyertownasd.org
Phone: 610-473-3507 or extension 3507

Keep the remainder of the packet for future reference.

Read all information in the packet carefully. Please call Cindi with any questions or concerns.

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BOYERTOWN AREA SCHOOL DISTRICT EMPLOYEE INCIDENT REPORT

SECTION ONE: EMPLOYEE INFORMATION

1. Name: _____
2. Street Address: _____
3. City: _____ State: _____ Zip: _____ County: _____
4. SSN: _____ DOB: _____
5. Job Tile: _____
6. Phone: _____ Alternative Phone: _____
7. Email Address: _____

SECTION TWO: OCCURRENCE INFORMATION

1. Date of Injury: _____ Start Time of Employee Shift _____
2. Time of Injury: _____ End Time of Employee Shift _____
3. Location of Injury
   a. **Choices:** Senior High, Ed Center, Support Services, Middle School East, Middle School West, Washington, Boyertown, Colebrookdale, Earl, Gilbertsville, New Hanover, Washington
   _____
   b. **Examples:** classroom, hallway, playground, parking lot, etc.
   _____
4. Type of Injury (concussion, contusion, fracture, sprain, burn, etc): _____
5. Accident Cause: _____
   (Fall From, Strain/Overexertion, Slip/Fall, Caught In-Between, Struck Against or By, Heat or Cold, Cut/Puncture/Scrape, Motor Vehicle Accident, etc)
6. Body Part(s) Injured: _____
7. Description of Accident: _____
   _____
   _____
   _____
8. Witnesses: _____
9. Incident Reported to: _____
10. Date Supervisor or Principal Notified: _____
11. Name of Supervisor or Principal: _____

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SECTION THREE: MEDICAL TREATMENT

☐ No treatment elected (please sign page 3)

☐ Medical treatment elected (please complete and sign section 3)

SECTION FOUR: INFORMATION IF SEEKING MEDICAL TREATMENT

NOTE: Employees must choose one of the medical providers listed on the provider panel on Page 5 when seeking treatment for a Workers' Compensation injury.

List the chosen medical provider below.

1. Physician/Health Care Provider Name and Address:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: _____ Fax: _____

2. Hospital Name and Address:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone Number: _____ Fax: _____

3. Date of this report: _____

4. Employee's Signature _____

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Boyertown Area School District - Boyertown 19512

Your Workers' Compensation Insurance Carrier is:

Encova Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

Name	Address	Phone	Area of Specialty
Tower Health Urgent Care (Multiple Locations)	1050 East Philadelphia Avenue Gilbertsville, PA 19525	484-659-0100	Urgent Care/Occupational Medicine
St. Luke's Care Now (Multiple Locations)	2793 Geryville Pike Pennsburg, PA 18073	267-424-8005	Urgent Care/Occupational Medicine
Occupational Health Pottstown Hospital-Tower Health	81 Robinson Street Pottstown, PA 19464	610-326-2300	Occupational Medicine
Rothman Orthopaedic Institute (Multiple Locations)	400 Enterprise Drive, 2nd Floor Limerick, PA 19468	267-339-3776	Orthopedics
Premier Orthopaedics (Multiple Locations)	1561 Medical Drive Pottstown, PA 19464	610-792-9292	Orthopedics
Philadelphia Hand to Shoulder Center (Multiple Locations)	300 Springhouse Drive, 2nd Floor Collegeville, PA 19426	610-768-5959	Orthopedics - Hand/Wrist/Elbow
Pottstown Surgical Associates	1329 East High Street, Suite 1 Pottstown, PA 19464	610-326-8400	General Surgery
Einstein Neurosurgery Associates	100 Market Street, Providence Tower Center Collegeville, PA 19426	215-456-6127	Neurosurgery
Eye Consultants of PA (Multiple Locations)	293 Armand Hammer Blvd. Pottstown, PA 19464	610-327-8528	Ophthalmology

CONVENIENT NETWORK LOCATIONS LISTED BELOW

PCS PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
PCS Diagnostic Network	Call Toll Free for Closest Location	1-888-594-4001	Diagnostic Testing
Mitchell ScriptAdvisor	Call Toll Free for Closest Location	1-866-846-9279	Pharmacy

Panel Date: 9/12/2025

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RIGHTS AND DUTIES FORM

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.l)(l)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.l)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.l)(l)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties under Sec. 306 (f.l)(l)(i) and that I understand them to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

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MEDICAL RECORDS RELEASE

TO: Any licensed physician, chiropractor, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of my health, history, condition or well-being.

In accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, I, _____ (Claimant name), _____ (Claim number) hereby authorize the use or disclosure of my individually identifiable health information described below to ENCOVA INSURANCE (Company name), **P.O. Box 3151 Charleston, WV 25322.**

For purposes of this Authorization, individually identifiable health information shall mean: Any and all of my personal health information created, received or obtained, including any medical or dental records, x- ray or radiology films, pathology materials, MedFlight reports, insurance-related documents and benefit forms, or any other medically-related record or item that relates to my physical health or condition, the provision of health care to me, or the payment for my care, as the foregoing information relates to the assessment, treatment, or recordation of history related to any injury to me or any disease that affects me regardless of the time or cause of the onset of said injury or disease.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, psychological or psychiatric treatment, social services counseling, communicable diseases or infections, tuberculosis and hepatitis. Such records will be released through this authorization unless otherwise indicated. **Do not release any of the following information if an "x" appears before the description.**

_____ HIV/AIDS _____ Behavioral health _____ Drug and alcohol _____ Genetic history

I further authorize Recipient to use, disclose or re-disclose any and all of my above-described health information and to make copies thereof for purposes of evaluating and administrating an insurance claim I have filed with Recipient. I understand that my health information may be re-disclosed by Recipient and may then no longer be protected by any applicable federal or state privacy laws or regulations.

I understand that I may revoke this authorization at any time by sending a written notice of revocation to Recipient at the address listed above. I understand that my revocation will only be effective after it is received by Recipient and that the revocation will not apply to information that has already been released in response to this authorization.

This authorization shall expire on _____. If no date is specified, this authorization shall expire one year from the date it is signed. Any disclosures made prior to my revocation or prior to the expiration of this authorization will not be affected by my revocation or by the expiration of this authorization.

I understand and agree that a photocopy or electronically reproduced copy of the original of this authorization shall have the same effect as an original.

_____ Signature of individual

_____ Date

_____ Social Security number

_____ Date of birth

_____ Signature of personal representative, estate representative or guardian.

(Provide documentation of authority to act for individual.)

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