Washington County
First Report of Occupational Injury or Disease
(FROI)

General Information

Name: Last MI First	Date of Hire	Marital Status	Date of Birth
Address: P.O. Box/ Street City State Zip Code		Sex	Job title
Phone Number(s): Home: Cell:	Employee Department:		
☐ Full Time ☐ Temp ☐ Part Time ☐ Seasonal	# Dependants:	Area working while injured: Unit: Other:	
Date of Injury:	Date Reported:	Starting Time:	Time of Injury:
Physical description of where injury occurred: P.O. Box/ Street City State Zip Code			County/Parish:

Payroll Information
(Loss Prevention will complete shaded areas.)

Last day worked:	Average days/ week:	Average hours /day:
Weekly wage rate:	Wage rate period: **Bi-Weekly**	Salary continued: ☐Yes ☐ No
Did employee return to work: ☐Yes ☐ No ☐ Unknown	RTW Date (If known):	

Injury Description

Describe in detail what work activity the employee was performing when injured?

What is the root cause of this injury? List all completed or scheduled corrective actions regarding this matter.

Did the injury result from a mechanical defect? ☐Yes ☐ No	Unsafe Act? ☐Yes ☐ No
Were safeguards, PPE or safety equipment provided? ☐Yes ☐ No	Fatality? ☐Yes ☐ No

Injury Specifics

Puncture	Burn (Heat)	Fracture	Heart Attack
Crushed	Burn (Chemical)	Broken	Amputation
Impact	Rash	Dislocated	Inhaled
Cuts	Inflamed	Strain	Electric Shock
Abrasion	Bruises	Sprain	Other
Face	Arm Left Right	Hand Left Right	Groin Left Right
Head	Chest Left Right	Wrist Left Right	Leg Left Right
Neck	Elbow Left Right	Toes Left Right	Knee Left Right
Eyes Left Right	Back Left Right	Fingers Left Right	Ankle Left Right
Shoulder Left Right	Abdomen Upper Mid Low	Hip Left Right	Foot Left Right

To whom and when was the injury reported?	Time	Date
Witnesses:	Shift	Phone Number

Treatment: ☐ PCP ☐ Occ Med ☐ ER ☐ First Aid ☐ Declined Treatment

Describe First Aid Treatment: Who Administered it? (Include a detailed description of assessment/first aid)

Signature:	Date:

Effective 2.01.14

COUNTY COMMISSIONERS

DIANA IREY VAUGHAN
CHAIR
LARRY MAGGI
VICE CHAIR
NICK SHERMAN

(724) 228-6724

COUNTY OF WASHINGTON
COMMONWEALTH OF PENNSYLVANIA
100 WEST BEAU STREET, SUITE 202
WASHINGTON, PA 15301

HUMAN RESOURCES DEPARTMENT

(724) 228-6738
FAX: (724) 250-6570

SHELLI ARNOLD
DIRECTOR

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY EMPLOYER, THE COUNTY OF WASHINGTON, REGARDING THE WORK-RELATED INJURY SUSTAINED ON: _____.

EMPLOYEE INFORMATION

ADDRESS: _____ PHONE: _____

_____ DOB: _____

_____

EMPLOYEE (SIGNATURE): _____ DATE: _____

PENNSYLVANIA FRAUD STATEMENT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE OR DEFRAUD ANY INSURER FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION SHALL, UPON CONVICTION, BE SUBJECT TO IMPRISONMENT FOR UP TO SEVEN YEARS OR PAYMENT OF A FINE OF UP TO $50,000.

EMPLOYEE (SIGNATURE): _____ DATE: _____

For Use Beginning August 23, 1996

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 that 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 you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, 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 after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more that five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

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 from 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 HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKER'S COMPENSATION ACT AS SET FORTH HEREIN.

DATE: _____

_____
Employee

EMPLOYEE RE-NOTIFICATION

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Worker's Compensation Act. I have received a copy of this Worker's Compensation employee notification form.

DATE: _____

_____
Employee

May 10, 2017

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

If you suffer a work-related injury, immediately report the injury to your supervisor. Failure to do so may delay your benefits or may cause you to lose your rights to benefits. For necessary medical treatment and supplies to be paid by your employer:

- All treatment must be obtained from one of the healthcare providers listed below.

- You must continue to visit one of the healthcare providers listed below if you need treatment for 90 days from the date of your first visit. If one of the providers listed below refers you to another licensed specialist, those services will be paid.

- After this 90-day period, if you still need treatment, you may go to another healthcare provider for treatment as long as you notify your claims adjuster within five (5) days of your visit to a new provider.

- If a listed physician prescribes invasive surgery, you have the right to obtain a second opinion from a physician of your choice. If a second opinion differs from that of the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a detailed treatment plan. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.

If you are faced with a medical emergency, you may secure initial emergency treatment from any emergency facility. However, when the emergency is resolved, follow-up treatment must be obtained from one of the following healthcare providers. If you choose to treat with an out-of-state provider, you may be subject to balance billing.

NAME OF PROVIDER	STREET	CITY, STATE, ZIP	PHONE	SPECIALTY
Washington Health System Occ. Medicine	95 Leonard Ave., Ste. 401 Bldg. 1	Washington, PA 15301	724.223.3528	Occ. Medicine
Washington Health System- Express Care	155 Wilson Avenue	Washington, PA 15301	724.225.7000	Urgent Care
Washington Orthopedics & Sports Med.	95 Leonard Ave., Ste. 202 Bldg. 1	Washington, PA 15301	724.206.0610	Orthopedics
Orthopedic Institute	160 Gallery Drive, Ste. 144	McMurray, PA 15317	412.359.3895	Orthopedics
Thomas Deitrich, DDS	400 Jefferson Avenue	Washington, PA 15301	724.228.4880	Dentist

FOR PRESCRIPTION MEDICATIONS AND
DURABLE MEDICAL EQUIPMENT
OR
TO SCHEDULE PHYSICAL THERAPY, CHIROPRACTIC
AND DIAGNOSTIC IMAGING APPOINTMENTS,
AND
LOCATIONS CLOSE TO YOU,
PLEASE CALL

KEYSCRIPTS AT 1.866.446.2848

All of your healthcare provider bills and reports need to be sent to the following address for review and payment in accordance with the Pennsylvania Workers' Compensation Act:

Inservco Insurance Services, Inc.

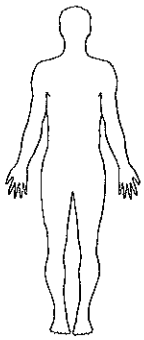
P.O. Box 3899, Harrisburg, PA 17105-3899

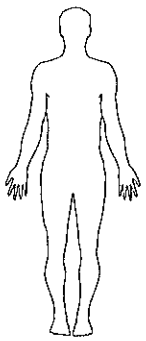
Phone: 1.800.356.0438 - Fax: 1.866.356.0438

Employee Statement

Please circle injured area(s)

Front





Back

Are you seeking medical treatment at this time? ☐ **Yes** ☐ **No**

Signature

Date

Supervisor Statement

Signature

Date

Witness Statement

Please give a contact number in case you need to be reached.

Contact Number _____

_____ _____

Signature *Date*