

BRYN MAWR

COLLEGE

Report of Work-Related Injury or Illness

To be completed by the supervisor with the employee, if possible. Complete and submit to EHS (ehs@brynmawr.edu) within 24 hours. Questions? Call EHS: (610) 526-5166.

Employee Information			
Employee Name		Date of Birth	
Job Title		Department	
Date of Hire		Hours	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
Student	<input type="checkbox"/> Yes <input type="checkbox"/> No	Start Time	
Employee Address	<hr/> <div style="display: flex; justify-content: space-between;"> Street City State Zip Code </div>		
Email Address:		Home Phone:	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Work Phone Ext:	
Number of children under the age of 18 at home:			

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Injury Information			
Date of Injury		Date Reported to Supervisor	
Time of Injury			
Detailed narrative of how the incident occurred:			
Where (building, room number, description of outdoor location)			
What was the employee doing just prior to the incident? Include job task, tools, or machinery used.			
Body Part Injured (ankle, lower back, etc.)			
Type of Injury (cut, sprain, fracture, burn, etc.)			
Does the Injury Require Medical Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lost Days of Work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Name of treating facility: _____

(In case of emergency, go to nearest hospital emergency room. For non-emergencies or follow up care, call Human Resources at 610-526-5261 for assistance in arranging treatment from a designated workers' compensation medical care provider.)

Name(s) of witnesses: _____ Telephone: _____

EMPLOYEE AUTHORIZATION: I hereby authorize my attending physician to release any information or copies thereof acquired during 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 _____ Date _____
(Print) (Signature)

Supervisor _____ Date _____
(Print) (Signature)

HR USE ONLY

PSN: _____

Rec Only LT RD MT

Date Filed _____

Claim No: _____

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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 you 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 you were 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.

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

Employee _____ Date _____
(Print) (Signature)