KEYSTONE SCHOOL DISTRICT
EMPLOYEE ACCIDENT REPORT

ALL EMPLOYEES MUST SEE THE SCHOOL NURSE OR THEIR SUPERVISOR AS SOON AS POSSIBLE IN ORDER TO FILE A REPORT

TODAY'S DATE____

EMPLOYEE'S NAME ____
STREET ADDRESS ____
CITY – STATE – ZIP ____
TELEPHONE NUMBER(S) _______________________________________
WHAT COUNTY DO YOU LIVE IN ________________________________

ARE YOU: MARRIED_________; SINGLE_________; DIVORCED_________
HOW MANY DEPENDENTS DO YOU HAVE? ___________________________

ARE YOU A DIABETIC? ____

DATE STARTED PRESENT JOB ___________________________________
SCHOOL BUILDING____________________JOB TITLE__________________
TIME SHIFT BEGINS ______________ TIME SHIFT ENDS ________________
HOW MANY HOURS PER DAY DO YOU NORMALLY WORK? ____________
HOW ARE YOU PAID? HOURLY_____; DAILY______; SALARIED_______

DATE OF ACCIDENT _______________ TIME OF ACCIDENT ___________

DATE & TIME WHEN REPORTED TO YOUR SUPERVISOR________________

BODY AREA INJURED ____

TYPE OF INJURY ____
(examples: sprain; fracture; cuts; bruising)

EXACT BUILDING LOCATION OF ACCIDENT__________________________

Using the space below, please answer the following questions…

WHAT WERE YOU DOING WHEN THE ACCIDENT OCCURED?
and….HOW WERE YOU INJURED?
PLEASE GIVE A DETAILED DESCRIPTION OF YOUR ACCIDENT.
BE SPECIFIC AND "GIVE FULL DETAILS"
You may use the back of this sheet or additional paper if necessary!

____

____

____

ANY UNSAFE ACTS OR CONDITIONS EXISTING? YES_______ NO_______
IF YES, PLEASE EXPLAIN____

SPECIFY ANY EQUIPMENT / MACHINERY INVOLVED______________________

WITNESSES: NAME________________________NAME________________________

WAS FIRST AID GIVEN? YES______ NO_______
NAME OF PERSON ADMINISTERING FIRST AID____________________________
WHAT WAS THE TREATMENT GIVEN____________________________________

____

WAS EMPLOYEE SENT TO A PHYSICIAN OR HOSPITAL? YES_____ NO______
IF YES, NAME OF PERSON WHO DROVE EMPLOYEE_______________________
NAME OF PHYSICIAN OR HOSPITAL_____________________________________

DID OR WILL EMPLOYEE MISS ANY WORK? YES______ NO________
IF YES, NUMBER OF DAYS MISSED ____________

SIGNATURES AND DATES: Employee _________________________________

Supervisor ________________________________

Nurse ____________________________________

Principal __________________________________

COMMENTS OR RECOMMENDATIONS FOR PREVENTING OTHER ACCIDENTS OF THIS TYPE____

____

Please forward this original and completed signed form to the District Office.
Thank you!

Revised September 23 , 2015 (sr)

LIST INJURED AREA AND TYPE OF INJURY______________________

____

____

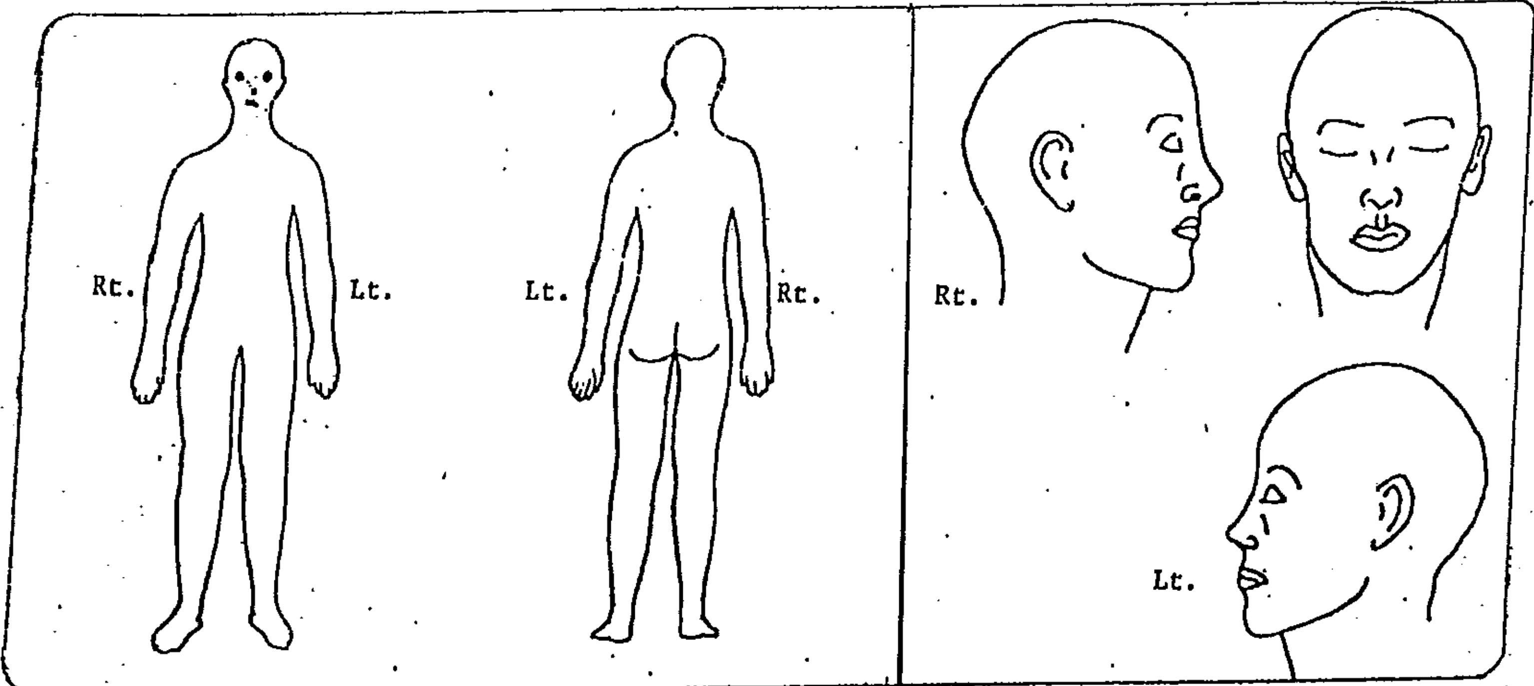
PLEASE NOTE THE EXACT LOCATION OF THE INJURY BY PLACING A NUMBER ON THE MODEL BELOW.
USE THE LINES BELOW TO DESCRIBE THE CORRESPONDING INJURY THAT EACH NUMBER REPRESENTS

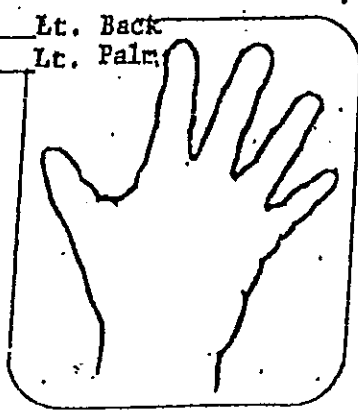
1.______________________ 5.______________________

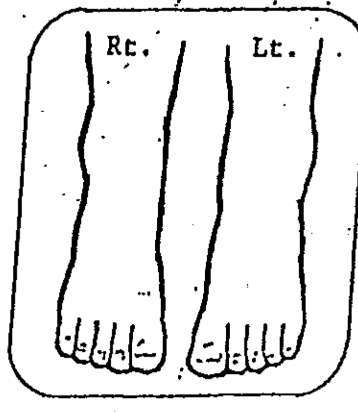
2.______________________ 6.______________________

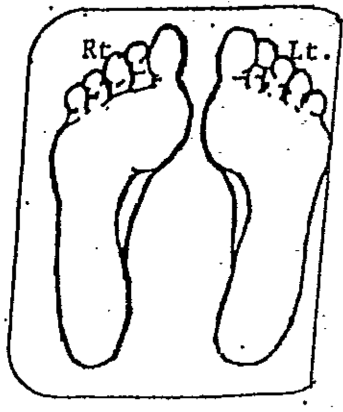
3.______________________ 7.______________________

4.______________________ 8.______________________









NOTICE TO ALL EMPLOYEES

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY

Section 306(f) of the Pennsylvania Workers' Compensation Act provides for the payment of medical treatment for work-related injuries including an addidtional opinion when invasive surgery may be necessary. The information below describes your responsibilities if you are injured. PLEASE READ CAREFULLY.

Your employer has provided for the payment of benefits under the Workers' Compensation Act of Pennsylvania with:

Selective Insurance Company of New York

WC 9018280

KEYSTONE SCHOOL DISTRICT

IN CASE OF WORK-RELATED INJURY OR DISEASE

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and suplies, orthopedic appliances and prostheses, including tranining in their use.
2. In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from the physicians or other health care providers listed below:
3. You must continue to visit one of these listed providers, if you need treatment, for at least 90 days from the date of your first visit.

★ †Family Chiropractic of Knox
Chiropractor
108 Rossman Ave
Knox, PA 16232
814-797-2863
Est Dist: 7.7 MI

★ Marianne Family Practice
Family Practice
21159 Paint Boulevard, Suite 2
Shippenville, PA 16254
814-226-6770
Est Dist: 5.6 MI

★ Northwest Eye Associates
Ophthalmology
312 13th Street
Franklin, PA 16323
814-437-2444
Est Dist: 19.4 MI

★ Oil City Physical Therapy
Physical Therapy
1054 1/2 Grandview Rd
Oil City, PA 16301
814-677-7742
Est Dist: 16.8 MI

★ Orthopedics & Sports Medicine Associates
Surgery: Orthopedic
342 South 5th Avenue
Clarion, PA 16214
814-226-4270
Est Dist: 7.6 MI

★ Park, Chong
Surgery: Orthopedic
24 Doctors Lane
Clarion, PA 16214
814-226-7800
Est Dist: 7.6 MI

★ Rezek, Donald, M.D.
Neurology
505 Poplar St
Meadville, PA 16335
814-337-5775x,8143375975
Est Dist: 42.2 MI

★ Seneca Medical Center, LLC -- Dba: Workers Care
Occupational Medicine
One Park Way, PO Box 802
Seneca, PA 16346
814-677-1768
Est Dist: 13.6 MI

★ West Park Rehab
Physical Therapy
571 Pone Lane
Franklin, PA 16323
814-437-6191, 814-437-6922
Est Dist: 18.7 MI

Diagnostics: Spreemo
Phone: 800-595-7173
www.spreemo.com

Pharmacy: First Script
Phone: 800-791-2080
www.firstscript.com

4. If one of the providers listed above refers you to another physician or other health care providers, your employer or its insurer will pay the reasonable bills for these services.
5. Should invasive surgery be prescribed by a physician or other health care providers so designated by your employer, you are permitted to receive an additional opinion from any health care provider of your choice. (Refer to Section 306(f.1)(1)(i) for further information pertaining to invasive surgery.)
6. Following termination of the applicable period for treating with one of the providers listed above, if you still need treatment, you may choose to remain with a provider on the panel or choose to go to another physician or other health care provider of your choice. If you choose a provider not on the panel, you should notify your employer and its insurance company of this action within 5 days of your visit to the provider of your choice. Your bills will be paid for if your physician or other health care provider files reports as required. These reports must be filed within 10 days after your first visit or at least once a month for as long as treatment continues.
7. If you are faced with a medical emergency, you may secure assistance from a hospital or physician or other health care provider of your choice. You must then seek subsequent treatment from a physician or other health care provider listed above for at least the first 90 days of the necessary treatment, from the date of your first visit.

† = Denotes that the original provider record has been changed.

This Directory of Medical Providers has been prepared by your employer's workers compensation insurance carrier. It is intended to present information concerning hospitals, physicians and other medical care providers. This information contained in this Directory was accurate and up-to-date as of the publication date. Please note that we are not responsible for any omissions, errors or changes that occur after the date of publication.

Sequence: S001042897