

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

General Information						
Name:			Date of Hire	Marital Status	Date of Birth	
Last	MI	First				
Address:				Sex	Job title	
P.O. Box/ Street		City	State	Zip Code		
Phone Number(s):			Employee Department:			
Home:		Cell:				
<input type="checkbox"/> Full Time	<input type="checkbox"/> Temp	# Dependents:		Area working while injured:		
<input type="checkbox"/> Part Time	<input type="checkbox"/> Seasonal			Unit:	Other:	
Date of Injury:		Date Reported:		Starting Time:	Time of Injury:	
Physical description of where injury occurred:					County/Parish:	
P.O. Box/ Street		City	State	Zip Code		
Payroll Information						
<i>(Loss Prevention will complete shaded areas.)</i>						
Last day worked:		Average days/ week:		Average hours /day:		
Weekly wage rate:		Wage rate period: Bi-Weekly		Salary continued: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did employee return to work: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				Unsafe Act? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Were safeguards, PPE or safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No				Fatality? <input type="checkbox"/> Yes <input type="checkbox"/> 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
Head	Chest	Left	Right	Wrist	Left	Right
Neck	Elbow	Left	Right	Toes	Left	Right
Eyes	Back	Left	Right	Fingers	Left	Right
Shoulder	Abdomen	Left	Right	Hip	Left	Right
	Low					
To whom and when was the injury reported?				Time	Date	
Witnesses:			Shift	Phone Number		
Treatment: <input type="checkbox"/> PCP <input type="checkbox"/> Occ Med <input type="checkbox"/> ER <input type="checkbox"/> First Aid <input type="checkbox"/> Declined Treatment						
Describe First Aid Treatment: Who Administered it? (Include a detailed description of assessment/first aid)						
Signature:				Date:		

COUNTY COMMISSIONERS

LARRY MAGGI
CHAIRMAN
DIANA IREY VAUGHAN
VICE CHAIRMAN
HARLAN G. SHOBER, JR.

(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

KATHLEEN M. BALI
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: _____



IN THE EVENT OF A WORK INJURY, TELL YOUR SUPERVISOR
 If you are injured while at work, your employer has arranged for payment of your medical care with

COUNTY OF WASHINGTON/ INSERVCO

It is your responsibility to immediately report the injury to your supervisor.

IN CASE OF A WORK-RELATED INJURY OR DISEASE

rev 2/1/14

IN ACCORDANCE WITH THE PENNSYLVANIA WORKERS' COMPENSATION ACT, YOU MUST CHOOSE A MEDICAL PROVIDER FROM THE LIST BELOW: If you suffer a work-related injury or disease, your employer or its insurance company will pay for reasonable surgical and medical services, medication, supplies, orthopedic appliances and prostheses, including training in their use. 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 licensed physicians or practitioners of the healing arts listed below:			
Medical Provider	Address	Telephone	Specialty
Washington Hospital Occupational Medicine Center	95 Leonard Ave., Suite 401 Building 1, Floor 4 Washington, PA 15301	724-223-3528	Occupational Medicine
Anthony N. Ricci, M.D.	400 Jefferson Ave. Washington, PA 15301	724-228-4106	Physical Medicine
Washington Orthopedics and Sports Medicine	95 Leonard Ave., Suite 202 Building 1, Floor 2 Washington, PA 15301	724-206-0610	Orthopedic Providers
UPMC Orthopaedic Specialists	Various Locations Washington County	1-877-471-0935	Orthopedic Providers
Genex Services, Inc. Medical Diagnostics	Multiple Locations	1-800-310-3926	MRI / CT/ Ultrasound
Thomas Deitrich DDS	400 Jefferson Ave. Washington, PA 15301	724-228-4880	Dentist
Chiropractic Care Center Dr. Duane Marasco	24 Wilson Avenue Washington, PA 15301	724-223-9700	Chiropractic Medicine
Bradley Physical Therapy	382 W. Chestnut St. Washington, PA 15301	724- 228-2911	Physical Therapy
NovaCare Rehabilitation	Multiple Locations Washington County	1-800-824-1323	Physical Therapy

I _____, recognize and agree that my employer has posted a list of at least six (6) health care providers to treat work-related injuries and illnesses during the first 90 days of treatment. I also acknowledge that I have received and reviewed the Workers' Compensation Health Care Provider Panel.

Signature

Date



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EMPLOYEE COPY

If you need an appointment scheduled, please contact Loss Prevention.
 In the event Loss Prevention is unavailable, please contact Human Resources.



WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.dli.state.pa.us, PA keyword: workers' comp

TIME OF HIRE

DATE OF INJURY

OTHER

I, _____, employee of Washington County, hereby certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Employee Signature: _____ Date: _____



PENNSYLVANIA WORKERS' COMPENSATION ACT
RIGHTS AND DUTIES

1. The employee has 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.
2. The employee has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.
3. The employee has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
4. The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall pay for the treatment rendered by the referral provider.
5. The employee has the right to seek emergency medical treatment from any provider, but that subsequent nonemergency treatment shall be by a designated provider for the remainder of the 90-day period.
6. The employee has the right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
7. The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.
8. The employee has the duty to notify the employer of treatment by a non-designated provider 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. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
9. The employee has the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

TIME OF HIRE

DATE OF INJURY

OTHER

I hereby acknowledge that I have been presented with this written notice setting forth my rights and duties under Section 306(f.1)(1)(i) of the Workers' Compensation Act.

Employee: _____ Date: _____

Witness: _____ Date: _____

