NOTICE TO ALL EMPLOYEES OF SHAMOKIN AREA SCHOOL DISTRICT

If you are injured while at work, your employer has arranged for the payment of your workers' compensation benefits with Excalibur Insurance Management Services LLC at 570-969-4074. It is your responsibility to immediately report the injury to your supervisor.

IN ACCORDANCE WITH THE PENNSYLVANIA WORKERS' COMPENSATION ACT, YOU MUST CHOOSE A PHYSICIAN OR OTHER HEALTH CARE PROVIDER FOR THE FIRST 90 DAYS FROM THE LIST OF PHYSICIANS OR OTHER HEALTH PROVIDERS ON PAGE 2.

IN CASE OF WORK-RELATED INJURY OR DISEASE

If you suffer a work-related injury, Excalibur Insurance Management Services LLC will pay for reasonable and necessary surgical and medical services, medicines, supplies, orthopedic appliances and prostheses, including training in their use.

In order to ensure that your medical treatment will be paid for by Excalibur Insurance Management Services LLC, you must select from one of the physicians or other health care providers as listed on Page 2.

You must continue to visit one of these physicians or other health care providers listed above, if you need treatment, for 90 days from the date of your first visit.

After this 90-day period, if you still need treatment, you may choose to go to another physician or other health care provider for treatment. If this situation should arise let your employer and your Excalibur Insurance Management Services LLC Representative know within 5 days of the first visit.

All physicians and other health care providers must file reports within 10 days after your first visit and at least once a month for as long as treatment continues in order for payment to be considered.

If one of the physicians or other health care providers listed on **Page 2** refers you to another physician or health care provider **Excalibur Insurance Management Services LLC** will pay the reasonable and necessary bills for these services.

If you're faced with an *immediate medical emergency* you may secure initial assistance from a hospital, physician or other health care provider of your choice. You must then seek subsequent treatment from a physician or other health care provider listed on Page 2 for at least the first 90 days from the date of your first treatment.

If one of the listed providers recommends invasive surgery, you are entitled to a second opinion from a physician of your choice. Should your physician's opinion differ, and you choose that opinion, the panel physician will abide by same for 90 days.

Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact materials thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read all of the above regarding treatment for my Workers' Compensation injury.

_____ _____

Employee Signature **Date**

EXCALIBUR INSURANCE MANAGEMENT SERVICES LLC
213 SMITH STREET, DUNMORE PA 18512
PH: (570) 969-4074
FAX: (570) 969-4172 or (570) 504-0627

FOR EMPLOYEES OF SHAMOKIN AREA SCHOOL DISTRICT
WORKERS COMPENSATION
PANEL OF PHYSICIANS

MEDICAL PROVIDER	ADDRESS	TELEPHONE	SPECIALTY
EFFECTIVE JULY 1, 2018			
MEDEXPRESS URGENT CARE - SELINSGROVE	1597 N. SUSQUEHANNA TRAIL SELINSGROVE, PA 17870	570-743-7821	*EMERGENCY CARE* URGENT CARE/WALK-IN CLINIC
GEISINGER-SHAMOKIN AREA HOSPITAL	4200 HOSPITAL ROAD COAL TOWNSHIP, PA 17866	570-644-4200	*GENERAL ACUTE CARE
CENTRAL SUSQUEHANNA SURGICAL SPECIALISTS	25 LYSTRA ROGERS DRIVE LEWISBURG, PA 17837	570-523-3290	SURGERY - GENERAL
WORKPLACE HEALTH	521 N. FRANKLIN STREET SHAMOKIN, PA 17872	570-509-2642	OCCUPATIONAL MEDICINE
PHOENIX REHAB & HEALTH SYSTEMS	541 N. FRANKLIN STREET SHAMOKIN, PA 17872	570-644-2000	PHYSICAL/OCCUPATIONAL THERAPY
MOUNT CARMEL OUTPATIENT REHAB AND FITNESS CLINIC	2616 LOCUST GAP HIGHWAY MOUNT CARMEL, PA 17851	570-339-3909	PHYSICAL/OCCUPATIONAL THERAPY
SUN ORTHOPAEDIC GROUP	289 S. MARKET STREET ELYSBURG, PA 17824	800-598-5096	ORTHOPEDIC SURGERY
ONE CALL CARE MGMT.	FOR LOCATIONS & APPTS., CALL THE TOLL-FREE NUMBER	800-872-2875	IMAGING/RADIOLOGY/MRI
THE EYE CENTER	1172 STATE ROUTE 487 PAXINOS, PA 17860	570-286-1295	OPHTHALMOLOGY
RAJNISH P. CHAUDRY MD	1 NORWEGIAN WOODS DR, STE 205 POTTSVILLE, PA 17901	570-622-2100 SCHEDULING 800-225-9675	NEUROLOGY
PHILLIPS CHIROPRACTIC CENTER	34 N. 6TH STREET SUNBURY, PA 17801	570-286-0170	CHIROPRACTIC CARE
OPTUM/MODERN MEDICAL (PRESCRIPTION CARD)(VIA US MAIL)	PRESCRIPTION CARD ACCEPTED AT ALL PHARMACIES	1-800-547-3330	PHARMACY RX & MEDICAL EQUIP. DEVICES

* Follow Up with a Panel Occupational Medicine Provider for Continuing Treatment

** Pharmacy Benefit Manager for RX (Prescriptions).

*** Attempted Misuse of RX Card will be referred to Fraud Division.

REMINDER

In order to ensure that your medical treatment will be paid for by Excalibur Insurance Management Services LLC, you must select from one of the physicians or healthcare providers as listed above.

You must continue to visit one of these physicians or other health care providers listed above, if you need treatment, for 90 days from the date of your first visit.

After this 90-day period, if you still need treatment, you may choose to go to another physician or health care provider for treatment. If this situation should arise, let your employer know and your Excalibur Insurance Management Services Representative know within 5 days of the first visit.

I have read all of the above regarding treatment for my Workers' Compensation injury.

_____ _____

Employee Signature Date

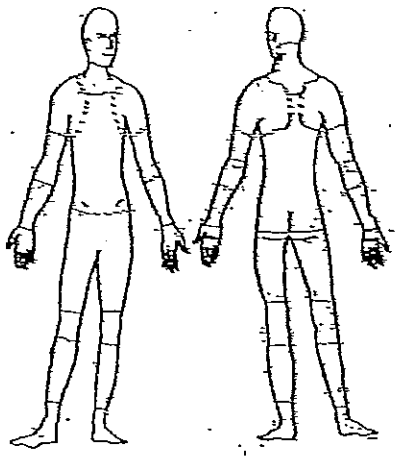
EXCALIBUR INSURANCE MANAGEMENT SERVICES LLC
213 SMITH STREET, DUNMORE PA 18512
PH: (570) 969-4074 FAX: (570) 969-4172 or (570) 504-0627

Incident Investigation Report

Instructions: Complete this form as soon as possible after an incident that results in serious injury or illness. (Optional: Use to investigate a minor injury or near miss that *could have resulted in a serious injury or illness.*)

This is a report of a: ☐ Death ☐ Lost Time ☐ Dr. Visit Only ☐ First Aid Only ☐ Near Miss	
Date of incident:	This report is made by: ☐ Employee ☐ Supervisor ☐ Team ☐ Other: _____

Step 1: Injured employee (complete this part for each injured employee)

Name:	Sex: ☐ Male ☐ Female	Age:
Department:	Job title at time of incident:	
Part of body affected: (shade all that apply) 	Nature of injury: (most serious one) ☐ Abrasion, scrapes ☐ Amputation ☐ Broken bone ☐ Bruise ☐ Burn (heat) ☐ Burn (chemical) ☐ Concussion (to the head) ☐ Crushing Injury ☐ Cut, laceration, puncture ☐ Hernia ☐ Illness ☐ Sprain, strain ☐ Damage to a body system ☐ Other _____	This employee works: ☐ Regular full time ☐ Regular part time ☐ Seasonal ☐ Temporary Months with this employer: Months doing this job:

Step 2: Describe the incident

Exact location of the incident:	Exact time:
What part of employee's workday? ☐ Entering or leaving work ☐ Doing normal work activities ☐ During meal period ☐ During break ☐ Working overtime ☐ Other: _____	
Names of witnesses (if any):	

Number of attachments:	Written witness statements:	Photographs:	Maps / drawings:

What personal protective equipment was being used (if any)?

Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.

Description continued on attached sheets: ☐

Step 5: Why did the incident happen?

Unsafe workplace conditions: (Check all that apply)
- ☐ Inadequate guard
- ☐ Unguarded hazard
- ☐ Safety device is defective
- ☐ Tool or equipment defective
- ☐ Workstation layout is hazardous
- ☐ Unsafe lighting
- ☐ Unsafe ventilation
- ☐ Lack of needed personal protective equipment
- ☐ Lack of appropriate equipment / tools
- ☐ Unsafe clothing
- ☐ No training or insufficient training
- ☐ Other: _____

Unsafe acts by people: (Check all that apply)
- ☐ Operating without permission
- ☐ Operating at unsafe speed
- ☐ Servicing equipment that has power to it
- ☐ Making a safety device inoperative
- ☐ Using defective equipment
- ☐ Using equipment in an unapproved way
- ☐ Unsafe lifting
- ☐ Taking an unsafe position or posture
- ☐ Distraction, teasing, horseplay
- ☐ Failure to wear personal protective equipment
- ☐ Failure to use the available equipment / tools
- ☐ Other: _____

Why did the unsafe conditions exist?

Why did the unsafe acts occur?

Is there a reward (such as "the job can be done more quickly", or "the product is less likely to be damaged") that may have encouraged the unsafe conditions or acts? ☐ Yes ☐ No
If yes, describe:

Were the unsafe acts or conditions reported prior to the incident? ☐ Yes ☐ No

Have there been similar incidents or near misses prior to this one? ☐ Yes ☐ No

Step 5: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

☐ Stop this activity ☐ Guard the hazard ☐ Train the employee(s) ☐ Train the supervisor(s)

☐ Redesign task steps ☐ Redesign work station ☐ Write a new policy/rule ☐ Enforce existing policy

☐ Routinely inspect for the hazard ☐ Personal Protective Equipment ☐ Other: ____________________

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets: ☐

Step 6: Who completed and reviewed this form? (Please Print)

Written by: Department:	Title: Date:

Names of investigation team members:

Reviewed by:	Title: Date:

OSHA's Form 301
Injury and Illness Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This *Injury and Illness Incident Report* is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the *Log of Work-Related Injuries and Illnesses* and the accompanying *Summary*, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains.

If you need additional copies of this form, you may photocopy and use as many as you need.

Completed by _____

Title _____

Phone (____) _____ Date ____/____/____

Information about the employee

1) Full name _____

2) Street _____

City _____ State _____ ZIP _____

3) Date of birth ____/____/____

4) Date hired ____/____/____

5) ☐ Male
☐ Female

Information about the physician or other health care professional

6) Name of physician or other health care professional _____

_____

7) If treatment was given away from the worksite, where was it given?

Facility _____

Street _____

City _____ State _____ ZIP _____

8) Was employee treated in an emergency room?
☐ Yes
☐ No

9) Was employee hospitalized overnight as an in-patient?
☐ Yes
☐ No

Information about the case

10) Case number from the *Log* _____ *(Transfer the case number from the Log after you record the case.)*

11) Date of injury or illness ____/____/____

12) Time employee began work _____ AM / PM

13) Time of event _____ AM / PM ☐ Check if time cannot be determined

14) ***What was the employee doing just before the incident occurred?*** Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

15) ***What happened?*** Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

16) ***What was the injury or illness?*** Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." *Examples:* "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

17) ***What object or substance directly harmed the employee?*** *Examples:* "concrete floor"; "chlorine"; "radial arm saw." *If this question does not apply to the incident, leave it blank.*

18) ***If the employee died, when did death occur?*** Date of death ____/____/____