

**EMPLOYEE INFORMATION**

NAME: \_\_\_\_\_ GENDER: Male:   
Female:

ADDRESS: \_\_\_\_\_  
Street City State/Zip  
*(Please give complete address including Zip Code otherwise claim cannot be processed)*

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

MARITAL STATUS: Single   
Married

OCCUPATION: \_\_\_\_\_ DEPT: \_\_\_\_\_

WORK PHONE #: (\_\_\_\_) \_\_\_\_\_ DATE OF HIRE AT DREXEL: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PAYROLL SCHEDULE: Monthly   
Bi-Weekly   
Weekly  LAST FULL DAY PAID: \_\_\_\_\_

WORK SCHEDULE: \_\_\_\_\_ Full time  Part time   
(example: M-F, 8:00am – 5:00pm) Hours per week: \_\_\_\_\_

**ACCIDENT INFORMATION**

DATE OF INJURY: \_\_\_\_\_ TIME OF INJURY: \_\_\_\_\_ (example: 1:00pm)

DATE ACCIDENT/INJURY REPORTED: \_\_\_\_\_

DATE OUT OF WORK: \_\_\_\_\_ DATE RETURNED TO WORK: \_\_\_\_\_

PERSON INJURY REPORTED TO: \_\_\_\_\_

EXACT LOCATION OF INCIDENT: \_\_\_\_\_

WHAT YOU WERE DOING WHEN INJURY OCCURRED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOW DID INJURY OCCUR?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CHECK ONE:            UNSAFE ACT             MECHANICAL DEFECT             OTHER

LIST NAMES OF WITNESSES: \_\_\_\_\_  
\_\_\_\_\_

**INJURY AND MEDICAL TREATMENT**

NATURE AND LOCATION OF INJURY OR DISEASE (Specify part of body): \_\_\_\_\_  
\_\_\_\_\_

DATE TREATMENT FIRST SOUGHT: \_\_\_\_\_ CHECK HERE IF DID NOT TREAT

NAME OF PHYSICIAN or \_\_\_\_\_  ER\*\*  
PLACE OF TREATMENT: \_\_\_\_\_  Occupational Medicine

ADDRESS OF ATTENDING PHYSICIAN OR HOSPITAL: \_\_\_\_\_  
\_\_\_\_\_

*\*\*Anyone who treats at the ER **MUST** follow-up with Oc. Medicine within 48 hours of treating.  
The hours at WorkNet Oc. Medicine are Monday through Friday from 7:30am to 5:00pm*

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(as witness to employee's signature)

Supervisor's Name (please print): \_\_\_\_\_

**PLEASE FORWARD A COPY OF THIS FORM TO:**

**Office of Risk Management**  
The Left Bank  
3180 Chestnut Street, Suite 101  
Philadelphia, PA 19104

*Leslie Quinn*  
*Assistant Director*  
Phone: (215) 895-2292  
Fax: (215) 571-4518

Employees injured while working within the scope of their employment are eligible for worker's compensation. Worker's compensation will pay for all relevant medical and diagnostic treatment, as well as compensate employees unable to work due to their injury, within certain time limits. Please contact the Drexel Risk Manager for details.

**THE FOLLOWING PROCEDURE MUST BE FOLLOWED IN CASE OF WORK RELATED INJURY OR ILLNESS:**

**A. IMMEDIATELY REPORT THE INJURY TO YOUR SUPERVISOR.**

Any injury you sustain at work must be reported immediately to your supervisor. **Failure to do so may delay your benefits or cause you to lose your rights to benefits.**

**B. OBTAIN MEDICAL CARE FROM A MEDICAL HEALTH CARE PROVIDER LISTED BELOW.**

<b>Physician/ Specialty</b>	<b>Address/ Phone</b>
<b>WORKNET Occupational Medicine</b> Francis X. Burke, M.D. - Medical Director Brian Birkmire., PA <i>Treatment types: ALL non life-threatening injuries</i>	Hahnemann University Hospital Broad & Vine Streets Bobst Building, 1 <sup>st</sup> Floor, Room 131 Philadelphia, PA 19102 P: 215.762.8525 <i>Free Transportation/Hospital Accessibility</i>
<b>Chiropractor</b> Jeff Sklar, ACA	325 Cherry Street Philadelphia, PA 19106 P: 215.627.6279
<b>General Surgery</b> Constantinos Pavilides, M.D.	245 North Broad Street, Suite 400 Philadelphia, Pa. 19107 P: 215.568.1015
<b>Hand Specialist</b> David. Zelouf, M.D.	834 Chestnut Street Philadelphia, PA 19107 P: 215.521.3000 <i>Philadelphia Hand Center</i>
<b>Ophthalmology</b> Myron Yanoff, M.D., Yelena Doych, M.D., Prathima Thumma, M.D.	219 Broad Street, 3 <sup>rd</sup> Floor Philadelphia, PA 19107 P: 215.762.3937 <i>Drexel Eye Physicians</i>
<b>Orthopedics</b> James Tom, M.D., Frederic Kleinbart, M.D., Jay Zampini, M.D.	216 N. Broad Street Feinstein Building, 2 <sup>nd</sup> Floor Philadelphia, PA 19102 P: 215.762.2663 <i>University Orthopedic Institute</i>
<b>Orthopedics/Neurosurgery/Hand Specialty</b> Peter Deluca, M.D.; Mark Lazarus, M.D.; Paul Marchetto, M.D.; Nicholas Taweel, D.P.M., P.T.; Greg Anderson, M.D.	925 Chestnut St, 5 <sup>th</sup> Floor Philadelphia, PA 19107 P: 215.955.3458 <i>Group Name: Rothman Institute</i>
<b>Neurology</b> I. Howard Levin, M.D., Richard Katz, M.D., Richard Bennett, M.D.	405 Klein Bldg. 5401 Old York Road Philadelphia, PA 19141 P: 800.789.7366
<b>Neurosurgery</b> Francis Kralick, D.O., Joseph Queenan, M.D.	231 N. Broad Street, 1 <sup>st</sup> Floor Philadelphia, PA 19107 P: 215.762.3131 <i>Hahnemann Neurosurgery</i>
<b>Physical Therapy</b> Kevin Gard, PT, DPT, OCS, Robert Maschi, PT, DPT, OCS Noel Goodstadt, PT, DPT, OCS, Sarah Wenger, PT, DPT, OCS	Drexel University Physical Therapy 3 Parkway Building 1601 Cherry Street Philadelphia, Pa 19102 P: 215.553.7012 <i>Drexel University Physical Therapy</i>
<b>Physical Therapy</b> Michael Marchessani, PT	One Reed Street Philadelphia, PA 19147 P: 215.467.5800 <i>Free transportation available to appointments</i>

**C. MEDICAL EMERGENCY:**

If you are faced with a medical emergency, **you may secure initial emergency treatment from any emergency facility.** However, any follow-up care to the emergency treatment must be with a designated health care provider.

**D. FOR MEDICAL TREATMENT TO BE PAID BY YOUR EMPLOYER:**

- You must select one of the providers listed above.** If you choose to seek treatment from a provider not listed above within the first ninety (90) days of treatment **you will be held responsible for costs incurred.**
- You must continue** to visit one of the providers listed above or any specialist to which that provider refers you, if you need treatment, for **ninety (90) days from the date of your first visit.** This requirement is in conformance with the Pennsylvania Workers' Compensation Act, Section 306 (F) (1) (i).
- After Ninety (90) days,** if you still need treatment, you may continue with the same provider or you may choose to go to another provider for treatment. **If you decide to go to another provider, you must notify your employer of this action within five (5) days of your visit.**
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.

For any questions regarding your Workers' Compensation Claim, please contact **Chubb Insurance at 215-845-6022.**

## *Workers' Compensation Information*

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 when 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, including, without limitation, areas used for the 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 at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); [www.state.pa.us](http://www.state.pa.us), PA Keyword: workers comp.

I hereby acknowledge receipt of the "WORKERS' COMPENSATION INFORMATION" form.

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Employee Signature

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Supervisor Signature

Date \_\_\_\_\_

**NOTICE TO EMPLOYEE AND EMPLOYEE  
ACKNOWLEDGMENT OF RIGHTS AND RESPONSIBILITIES  
(WORK RELATED INJURIES)**

1. If you suffer a work-related injury or illness, your employer or its workers' compensation insurance company must pay for surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, which are reasonable, necessary and related to the work-related injury.
2. Your employer has posted in the departments of Human Resources and Risk Management at least six designated health care providers. In order to ensure that your reasonable and necessary medical treatment and supplies will be paid for by your employer or its workers' compensation insurance company during the first ninety (90) days of treatment, you must select and visit one of the listed health care providers, and continue to visit that health care provider or another of the listed health care providers for a period of ninety (90) days from the date of the first visit. As required by law, this list will include no more than four coordinated care organizations (as approved by the state), and no fewer than three physicians. You are permitted to switch from one health care provider on the list to another health care provider on the list during the ninety (90) day period.
3. The employer is not permitted to include on this list a physician or health care provider who is employed, owned or controlled by your employer or its workers' compensation carrier unless that employment, ownership or control is disclosed on the list.
4. You have the right to seek treatment from a provider not appearing on the list (referral provider) if you are referred to such provider by one of the designated providers appearing on the list. Your employer shall pay for the reasonable and necessary treatment rendered by the referral provider for the work-related injury.
5. You have the right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be rendered by a designated provider for the remainder of the ninety (90) day period.
6. If one of the designated providers prescribes or recommends invasive surgery, you may seek and receive an additional opinion from any health care provider of your own choice. The charge for this consultation will be paid by your employer. If the additional opinion differs from the opinion provided by the designated provider, you may choose which course of treatment to follow: provided, however, that the second opinion includes a specific and detailed course of treatment. If you choose to follow the procedures designated in the additional or second opinion, such procedures shall be performed by one of the designated providers for a period of ninety (90) days from the date of your visit to the physician rendering the second or additional opinion.
7. With regard to all other treatment (i.e., that not involving invasive surgery), you have the right to seek treatment or medical consultation from a non-designated provider during the ninety (90) day period, but such services shall be at your own expense during the applicable period of ninety (90) days.
8. Following the first ninety (90) days of treatment with the designated physician or other health care provider, subsequent treatment may be provided by any health care provider of your own choice. You must notify your employer that your care has been transferred to a non-designated provider within five (5) days of your first visit to the non-designated provider of your choice. Your 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 Utilization Review Organization, under Subchapter C (relating to medical treatment review).

I hereby acknowledge that I have received this notice, and that I understand my rights and responsibilities as set forth herein.

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Employee (Print Name)

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Employee (Signature)

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Date