# DREXEL UNIVERSITY
# REPORT OF EMPLOYEE INJURY

Answer all questions fully. If not applicable, reply N/A

## 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: XXX-XX-_____

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
PLACE OF TREATMENT: _____ ☐ ER**
☐ 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**
3020 Market Street, Suite 102
Philadelphia, PA 19104

*Sara Potter*
*Director of Risk Management*
Phone: (267) 359-6250
Email: sap383@drexel.edu

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 Office of Risk Management for details.

# Drexel University – Center City Campus

## PANEL OF PROVIDERS

**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.**

| Physician/ Specialty | Address/ Phone |
|---|---|
| **Concentra**<br>**Occupational Medicine**<br>Francis X. Burke, M.D. – Medical Director<br>***Treatment types: ALL non-life-threatening injuries*** | 219 N. Broad Street<br>1st Floor<br>Philadelphia, PA 19107-1511<br>P: 215.762.8525 ***Free transportation available*** |
| **General Surgery**<br>TBD | |
| **Hand Specialist**<br>David. Zelouf, M.D. | 834 Chestnut Street<br>Philadelphia, PA 19107<br>P: 215.521.3000 ***Philadelphia Hand Center*** |
| **Ophthalmology**<br>Mid-Atlantic Retina | 840 Walnut Street, Suite 1020<br>Philadelphia, PA 19107<br>P: 800-331-6634 |
| **Orthopedics**<br>James Carey, MD, MPH<br>Brian Sennett, MD,<br>Arsh Dhanota, MD, CAQSM<br>Kristopher Fayock, MD | 235 South 33rd Street<br>Weightman Hall, 1st Floor<br>Philadelphia, PA 19104<br>P: 215.662.3340<br>***Penn Sports Medicine*** |
| **Orthopedics/Neurosurgery/Hand Specialty**<br>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, 5th Floor<br>Philadelphia, PA 19107<br>P: 215.955.3458 ***Group Name: Rothman Institute*** |
| **Neurology**<br>I. Howard Levin, M.D., Richard Katz, M.D.,<br>Richard Bennett, M.D. | 405 Klein Bldg. 5401 Old York Road<br>Philadelphia, PA 19141<br>P: 800.789.7366 |
| **Physical Therapy**<br>Kevin Gard, PT, DPT, OCS, Robert Maschi, PT, DPT, OCS Noel Goodstadt, PT, DPT, OCS, Sarah Wenger, PT, DPT, OCS | Drexel Recreation Center 3315 Market Street, Rm 210<br>Philadelphia, Pa 19104<br>P: 215.571.4287<br>***Drexel University Physical Therapy*** |
| **Physical Therapy**<br>Michael Marchessani, PT | **The Navy Yard**<br>4050 S. 26th St., Suite 140<br>P: 215.467.5800 ***Free transportation available*** |

**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:**

1. **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.**
2. **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).
3. **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.**
4. 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 claim, please contact The Hartford: Amanda Orozco – 315-385-3614 or Nicholas Hoskin - 860-737-1774

# *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, PA Keyword: workers comp.

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

_____ _____

Employee Signature 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.

| Employee (Print Name) | Employee (Signature) | Date |
|---|---|---|

# NOTICE OF FAMILY MEDICAL LEAVE REQUEST

Under the Family Medical Leave Act (FMLA), you may be eligible for up to 12 workweeks of job-protected, unpaid leave. According to the University's Workers' Compensation policy, any leave taken as a result of a work-related injury or accident that also qualifies as a medical leave of absence will be charged against an eligible employee's allotment of Family and Medical Leave. ***Please be aware that a Family Medical Leave claim will be submitted on your behalf by Human Resources to run concurrently with your worker's compensation claim, in accordance with the aforementioned Workers' Compensation policy.*** Job protection and continuation of your benefits during your time out are dependent on the approval of your claim under the FMLA and are not guaranteed by filing a claim for workers' compensation even if the claim is approved for workers' compensation.

Important Action Items:

- Approval for leave under the FMLA guarantees job protection for up to 12 workweeks if approved.
- Approval for leave under the FMLA guarantees that your University benefits will remain in place while you are unable to work.
- Any lost time as a result of a work-related injury or accident that also qualifies as a medical leave of absence under the FMLA (if approved) will be charged against an eligible employee's Family and Medical Leave allotment.
- During your leave, you remain responsible for all benefit premiums, regardless of whether you are actively receiving a paycheck from the University.
- Benefit premiums while you are in an inactive pay status will be placed into arrears. Premium arrears will be recovered on the first check when you are back in an active pay status. To discuss payment options, please contact Katie Shannon in Human Resources (kms652@drexel.edu).
- Prior to your return to work, a release from your treating physician releasing you back to work must be presented to Risk Management and Human Resources (fax to 215-895-5813).

If you have a medical condition that you believe may rise to the level of a disability as defined by the Americans with Disabilities Act Amendments Act (ADAAA), and may need a reasonable accommodation in order to meet the essential functions of your job, you should contact the Office of Human Resources (HR) at Drexel University. HR can be reached by phone at 215-895-1410 and by email at hrdisability@drexel.edu. More information about registering with HR can be found at the following website: http://drexel.edu/disability-resources. Contacting HR is completely voluntary.

_____ _____

Employee Name Date

_____

Employee Signature