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

General Information

Name: Last MI First	Date of Hire	Marital Status	Date of Birth
Address: P.O. Box/ Street City State Zip Code		Sex	Job title
Phone Number(s): Home: Cell:	Employee Department:		
☐ Full Time ☐ Temp ☐ Part Time ☐ Seasonal	# Dependants:	Area working while injured: Unit: Other:	
Date of Injury:	Date Reported:	Starting Time:	Time of Injury:
Physical description of where injury occurred: P.O. Box/ Street City State Zip Code			County/Parish:

Payroll Information
(Loss Prevention will complete shaded areas.)

Last day worked:	Average days/ week:	Average hours /day:
Weekly wage rate:	Wage rate period: **Bi-Weekly**	Salary continued: ☐Yes ☐ No
Did employee return to work: ☐Yes ☐ No ☐ 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? ☐Yes ☐ No	Unsafe Act? ☐Yes ☐ No
Were safeguards, PPE or safety equipment provided? ☐Yes ☐ No	Fatality? ☐Yes ☐ No

Injury Specifics

Puncture Crushed Impact Cuts Abrasion	Burn (Heat) Burn (Chemical) Rash Inflamed Bruises	Fracture Broken Dislocated Strain Sprain	Heart Attack Amputation Inhaled Electric Shock Other
Face Head Neck Eyes Left Right Shoulder Left Right	Arm Left Right Chest Left Right Elbow Left Right Back Left Right Abdomen Upper Mid Low	Hand Left Right Wrist Left Right Toes Left Right Fingers Left Right Hip Left Right	Groin Left Right Leg Left Right Knee Left Right Ankle Left Right Foot Left Right

To whom and when was the injury reported?	Time	Date
Witnesses:	Shift	Phone Number

Treatment: ☐ PCP ☐ Occ Med ☐ ER ☐ First Aid ☐ Declined Treatment

Describe First Aid Treatment: Who Administered it? (Include a detailed description of assessment/first aid)

Signature:	Date:

Effective 2.01.14

COUNTY COMMISSIONERS

NICK SHERMAN
CHAIRMAN
ELECTRA S. JANIS
VICE CHAIR
LARRY MAGGI
COMMISSIONER

(724) 228-6724

COUNTY OF WASHINGTON
COMMONWEALTH OF PENNSYLVANIA
95 WEST BEAU STREET, SUITE 400
WASHINGTON, PA 15301

HUMAN RESOURCES DEPARTMENT

(724) 228-6738
FAX: (724) 250-6570

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: _____

County of Washington, PA
95 West Beau Street, Suite 400
Washington, PA 15301
01/11/2024

PENNSYLVANIA WORK-RELATED INJURIES

If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances, and prostheses, including training in their use.

To ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the designated health care providers listed below:

Occupational Medicine
Washington Health System
Multiple locations
95 Leonard Ave, Bldg. 1, Suite 401
Washington, PA 15301
724-223-3528

Orthopedic Surgery
Washington Orthopedics & Sports Med
95 Leonard Ave. Bldg. 1, Suite 202
Washington, PA 15301
724-206-0610

Orthopedic Surgery
Allegheny Orthopaedic Associates
Multiple locations
160 Gallery Drive, Suite 100
McMurry, PA 15314
412-359-3895

Chiropractor
Wano Chiropractic
1049 Waterdam Plaza Drive
McMurray, PA 15317
724-299-3706

Surgery: General
Angott Surgical Associates
Multiple locations
88 Wellness Way, Bldg. 1
Washington, PA 15301
724-222-9500

Ophthalmology
Southwestern PA Eye Center
Multiple locations
750 East Beau Street
Washington, PA 15301
724-228-2982

Chiropractor
Chiropractic Care Center
24 Wilson Avenue
Washington, PA 15301
724-223-9700

Neurology
St. Clair Medical Group
Neurology
1050 Bower Hill Rd. Suite 203
Pittsburgh, PA 15243
412-942-6300

Neurosurgery
AHN Neuroscience
380 West Chestnut Street
Suite 101
Washington, PA 15301
724-228-1414

Pharmacy-Any major pharmacy
Healthesystems Bin# 012874
877-528-9497
If assistance is needed, please take Injured Employee Prescription Fill Form to your pharmacy

For assistance with Physical Therapy or Durable Medical Equipment please contact Travelers.

Diagnostic Testing
One Call Care Management
Call for Scheduling
800-872-2875

**(NOTE: If any of the health care providers listed above are employer, owned or controlled by the employer or the employer's carrier, it will be so designated by an asterisk next to the health care provider's name.)
You must continue to visit one of these health care providers listed above, if you need treatment, for ninety (90) days from the date of your first visit.
After this ninety (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider. You **MUST** notify your employer of this action within five (5) days of your visit to the health care providers of your choice.
Your bills will be considered IF: your health care provider files written reports on a form prescribed by the Department (these reports must be filed within ten (10) days of commencing treatment and at least once a month thereafter, as long as treatment continues).
If one of the health care providers listed above refers you to another health care provider, your employer or its insured will pay the bill for these services provided they are reasonable and necessary.
If you are faced with a medical emergency, you may secure assistance from a hospital or health care provider of your choice.

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- 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.
- The right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
- The right to have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) 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.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM - SIDE 2

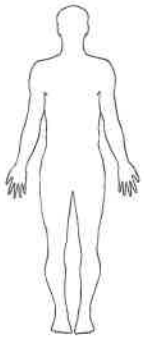
PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

Employee Statement

Please circle injured area(s)

Front



Back

Are you seeking medical treatment at this time? ☐ **Yes** ☐ **No**

Signature

Date

Witness Statement

Please give a contact number in case you need to be reached.

Contact Number _____

_____ _____

Signature *Date*

Supervisor Statement

Signature

Date

Healthesystems

Injured Employee Prescription Fill Form

TRAVELERS

Instructions for: Employer or Claim Handler

Please complete this form before providing to Injured Employee.

*Last Name, First Name:	*Social Security Number:
*Date of Injury:	*Date of Birth:
*Employer Name:	Claim Number if Known:

*Required Information

Instructions for: Injured Employee

To fill your prescriptions for a workers' compensation injury, follow these easy steps:

1. Present this form to your pharmacist.
2. Locate a participating pharmacy closest to you. For assistance use the following tools:
   - Call: 1.877.528.9497
   - Visit: www.healthesystems.com and click on "Pharmacy Search" located under the "Pharmacy Tools button"
   - A sample listing of pharmacies are provided at the bottom of this form

Instructions for: Pharmacists

Your pharmacy has contracted to participate in the Healthesystems Pharmacy Network.

First Fill Script:

To dispense the injured employee's first-fill for their workers' compensation prescription:

- Call the Healthesystems Customer Service Center: 1.877.528.9497
- Indicate that this is a new workers' comp injury; do not process under an existing injury
- Process using the temporary ID # provided by Healthesystems

Existing Claim:

- To dispense for ongoing scripts on an existing injury transmit using the Member ID #

Prescription Processing Information:

Transmit prescription using the following

Healthesystems Customer Service Center phone number: **1.877.528.9497** (press 1 for retail pharmacy option)		
BIN: **012874**	Carrier/Customer ID: **TRAVELERS**	* Member ID: *(provided by Healthesystems CSC representative)*

*Required Information

This Pharmacy Prescription Fill Form is not a guaranty of coverage by Travelers for prescriptions or any other benefits. Coverage depends on the facts and circumstance involved in the claim or loss, all applicable insurance policy or claim service contract provisions, and any applicable law.

Healthesystems Pharmacy Network

Albertson's	Giant Eagle	Medicap Pharmacy	Sam's Club	Walgreens
Bi-Lo Pharmacy	Giant Pharmacy	Medicine Shoppe	Sav-On Drugs	Wal-Mart
Brooks Pharmacy	HEB Pharmacy	Meijer Pharmacy	Shoprite Pharmacy	Winn Dixie P harmacy
Costco Pharmacy	Hy-Vee Pharmacy	Osco Drug	Stop & Shop	
CVS Pharmacy	Kmart	Publix Pharmacy	Target	
Duane Reade	Kroger Pharmacy	Rite Aid	VAMC	
Fred's Pharmacy	Long's Drug Store	Safeway Pharmacy	Vons Pharmacy	

Call 1.877.528.9497 or visit www.healthesystems.com to see a full list of network pharmacies.