Futures Community Support PCPA0740701
First Report of Occupational Injury or Disease

Record Type: ☐ RO = Report Only ☐ MO = Medical Only ☐ IND = Lost Time ☐ FA = Fatality

* Date of Injury: ___/ ___/ ___ (mm/dd/yyyy)

Employee Information:

* Employee First Name ____________ M/I ______ * Employee Last Name ____________

Employee Street Address ____________________

Employee Street Address 2 ____________________

Employee City ____________ State ________ Zip Code ____________

Employee Home Phone (______) _____ - _______ County ____________

Employee Social Security # _______ - _____ - _______

Gender ☐ Male ☐ Female

Employee Birth Date (mm/dd/yyyy) ___/___/_____

Employee Hire Date (mm/dd/yyyy) ___ / ___ / _____

Marital Status

☐ Single ☐ Divorced ☐ Widowed
☐ Married ☐ Separated ☐ Unknown

Employment Status

☐ Full Time ☐ Seasonal ☐ Other
☐ Part Time ☐ Volunteer

Dependents ____________ Department ____________ Occupation or Job Title ____________

Supervisor Name (first/Last) ____________________

Supervisor Phone (_____) _____ - _______

Employer Information:

* Member # PCPA0740701

* Member Name Futures Community Support

* Preparer Name (first/last) ____________________

* Preparer E-Mail ____________________

* Preparer Phone # (______) _____ - _______ Preparer Fax # (______) _____ - _______

NAICS Code 624120

Occurrence Information:

Injury Date ___ / ___ /_____

Time Began Work _____________ AM PM

Will Time be lost ☐ Yes ☐ No

Date Disability Began ____/____ /____

Date Returned to Work ____/____ /____

Full Pay Day of Injury ☐ Yes ☐ No

Time of Occurrence _____________ AM PM

Last Day Worked ____/____ /____

Date Employer Notified ____/____ /____

Occur on Premises ☐ Yes ☐ No

If not on Premises (explain): ____________________

____

____

Injury Information:

* Root Cause ______________________________

* Type of Injury/Illness ______________________________

* Body Part Affected ______________________________

* Accident Type ______________________________

Were Safeguards Provided? ☐ Unknown ☐ Yes ☐ No

Were Safeguards Used? ☐ Unknown ☐ Yes ☐ No

Equipment Used:

If Fatal, Give Date of Death (mm/dd/yyyy) ____ / ____ / ________

All Equipment, Materials, or Chemicals Employee was using when Accident/Injury Occurred

How Injury Occurred (Employee's Statement)

Treatment Information:

Initial Treatment

☐ No Medical Treatment ☐ Minor by Employee ☐ Clinic / Hospital ☐ Panel Physician

☐ Employee Physician ☐ Emergency Care ☐ Hospitalized More Than 24 Hours

Physician/Health Care Provider

First Name ______________________ Last Name ______________________

Street ______________________ City ______________________

State __________ Zip __________ Phone ______________________

Hospital/Clinic

Medical Facility ______________________________

Street ______________________ City ______________________

State __________ Zip __________ Phone ______________________

Witness Information:

Witness 1 (first/last) ______________________ (phone) ______________________

Witness 2 (first/last) ______________________ (phone) ______________________

Witness 3 (first/last) ______________________ (phone) ______________________

Is this a Questionable Claim? ☐ Yes ☐ No

Comments:

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act 165 and may also be subject to criminal and civil penalties.

NOTIFICATION OF EMPLOYEE'S RIGHTS AND DUTIES UNDER THE PENNSYLVANIA WORKERS' COMPENSATION ACT

In accordance with Section 306 (f.1)(1)(i) of the Pennsylvania Workers' Compensation Act and Section 127.755 of the Rules and Regulations of the Bureau of Workers' Compensation your employer is obligated to notify you of your rights and duties pertaining to medical treatment for a work injury and income status. You are required to acknowledge this notification of your rights and duties in writing.

Your employer has posted in the work place a list of at least six designated health care providers for treatment of work injuries.

You have the duty to obtain treatment for a work-related injury or illness from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.

You have 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.

You have the right, during this 90 day period, to switch from one health care provider on the list to another provider on the list, and this treatment will be paid for by your employer.

You have the right to seek treatment from a referral provider if you are referred by a designated provider. Your employer will pay for the treatment rendered by the referral provider.

You have the right to seek emergency medical treatment from any provider, but subsequent non-emergency treatment must be by a designated provider for the remainder of the 90 day period.

You have the right to seek treatment or medical consultation from a non-designated provider during the 90 day period, but these services shall be at your expense for the applicable 90 day period.

Should evasive surgery be prescribed for you by a designated provider, you have the right to seek a second opinion from any health care provider of your choice. However, you must return to the designated provider for follow up on any alternative treatment regimen that is recommended.

You have the right to seek treatment from any health care provider after the 90 day period has ended, and that treatment will be paid for by your employer, if it is reasonable and necessary.

You are required to regularly report receipt of all other income you receive While collecting workers' compensation, including: unemployment benefits, other wages, "old age" Social Security benefits, pension benefits and severance pay.

You have the duty to notify your employer of treatment by a non-designated provider within 5 days of the first visit to that provider. Your employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, your employer will be responsible to pay for these services once notified, unless the treatment is found to be unreasonable by a Utilization Review Organization in accordance with the provisions of the Workers' Compensation Act.

I hereby acknowledge that I have been informed of these rights and duties, and that I understand my responsibilities as set forth herein. I also understand that Bureau Regulation 127.755 specifically provides that an employee may not refuse to sign this acknowledgment of notification of their rights and duties in order to avoid any duties specified in this notice.

_______________________________ Employee Signature

_______________________________ Social Security Number

_______________________________ Date

DOCUMENTATION OF EMPLOYEE'S REFUSAL TO ACKNOWLEDGE NOTICE OF RIGHTS AND DUTIES IN CONNECTION WITH A REPORTED WORK INJURY.

The attached rights and notification form was present to ______________________________ on ____________________ in accordance with the requirements of Section 306 (f.1)(l)(i) of the Pennsylvania Workers Compensation Act and Section 127.55 of the Rules and Regulations of the Bureau of Workers' Compensation in connection with injury reported to have occurred on __________________ and the above employee refused to sign said document and acknowledge his/her duties and responsibilities as required.

____
Signature

____
Title

____
Date