RIVERVIEW
SCHOOL DISTRICT

Dr. Neil English, Superintendent
Ms. Sheila R Lubert, Director of Finance and Operations
Ms. Jamie Desroachers, Director of Special Education
Dr. David Turk, Director of Academics and Facilities

July 7, 2026

In accordance with section 306 of the Worker's Compensation Act, your employer is required to provide you with a written notice of the list of providers along with the instructions.

Attached is an updated list of Designated Physicians. Please read this notice and complete the page acknowledging and agreeing you have been presented with this notice.

Please return the completed form within ten (10) days of receipt. One copy should be kept for your records and return the completed copy to Cori B. Fye at Central Office.

If you should have any questions, please contact me at cfye@rsd.k12.pa.us.

Sincerely,

Cori B. Fye
Worker's Comp. Rep

PANEL ACKNOWLEDGEMENT FORM (PA ONLY)
2026-2027
Pennsylvania

CORVEL

NOTICE TO ALL EMPLOYEES

If you sustain a compensable accident while at work, your employer has arranged for the payment of your medical care with your insurance payor. It is your responsibility to immediately report the injury to your supervisor.

IN CASE OF INJURY

Employer. An injured employee must select a treating provider from the employer's properly posted listing of medical providers. Treatment with this provider shall be for (90) days from the date of the first visit for the work related injury or illness. Injured employees may choose another provider of their choice, or select from the employer/insurer's list after the first (90) days of treatment. Emergency medical care does not require preapproval and should be secured at the nearest location. The employer may not direct the employee to any specific provider on the list. The employee may switch from one designated provider to another designated provider. If a particular specialty is not on the list and the specialty is reasonable and necessary for treatment of the work injury, the employee will be allowed to treat with a health care provider of his or her choosing. Employers that establish a Coordinated Care Organization shall include an adequate number and specialty distribution of licensed health care providers in order to assure appropriate and timely delivery of services required under the act and appropriate flexibility to workers in selecting providers. Services may be provided directly, through affiliates or through contractual referral arrangements with other health care providers.

If you suffer a work-related injury, your insurance payor will pay for reasonable and necessary surgical, and medical services, medication, supplies, orthopedic appliances and prosthesis, including training in their use. In order to ensure that your medical treatment will be paid for by your insurance payor, you may select from one of the medical providers listed below. If the injury is a medical emergency, ensure that the injured employee is transported to the nearest emergency treatment facility. If you need assistance making an appointment for medical treatment, you may search for additional network providers at www.corvel.com/ppo-lookup/ or by calling 888-699-6655. Your Panel of Physician is attached hereto. Please speak with your supervisor now if you have any questions.

CORVEL

APPROVED FACILITIES TO SEEK TREATMENT

Oakmont PA 15139

Specialty	Name	Address	City	State	Zip	Phone
Urgent Care Center	UPMC Urgent Care	4145 William Penn Hwy	Monroeville	PA	15146	(412) 516-9134
Emergency Medicine	Ahn Harmar Neighborhood Hospital	2501 FREEPORT RD	PITTSBURGH	PA	15238	(330) 493-4443
Urgent Care Center	American Current Care of California A Medical Corp	15 FREEPORT RD #100	PITTSBURGH	PA	15215	(412) 784-1551
Urgent Care Center	Medexpress Urgent Care	50 Freeport Rd Ste 500	Aspinwall	PA	15215	(412) 782-3278
Occupational Medicine Center	Drayer Physical Therapy Institute LLC	333 Allegheny Ave Ste 102	OAKMONT	PA	15139	(412) 332-0716
Occupational Medicine Center	Concentra Medical Centers	15 Freeport Rd Ste 100	Aspinwall	PA	15215	(412) 784-1678
Orthopedic Surgery	Orthopedic Assoc of Pittsburgh Inc	5750 Centre Ave	Pittsburgh	PA	15206	(412) 361-2005
Physical Medicine & Rehab	Artuso, Frank B	2550 Mosside Blvd Ste 310	Monroeville	PA	15146	(412) 856-2440
Neurology	Rice, Eileen M	200 Delafield Rd Ste 2000	Pittsburgh	PA	15215	(412) 782-4211
Chiropractic	Greater Pgh. Sports Chiropractic	4328 Old William Penn Hwy	Monroeville	PA	15146	(412) 856-6262
Chiropractic	Kalkstein Chiropractic	200 Garden City Dr	Monroeville	PA	15146	(412) 373-9200
Chiropractic	Kalkstein Family Chiropractic LLC	3961 Monroeville Blvd	Monroeville	PA	15146	(412) 372-4343
	You may search for additional network providers at www.corvel.com/ppo-lookup/ Or by calling 888-699-6655					

I HAVE RECEIVED THIS PANEL OF PHYSICIANS AT THE REPORT OF MY INJURY

SIGNATURE

DATE

PRINT NAME

PERSON WHO WITNESSED THIS SIGNATURE

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG CASE #	REPORT PURPOSE CODE
Riverview School District 701 10th Street Oakmont PA 15139	JURISDICTION	JURISDICTION CLAIM NUMBER	
	INSURED REPORT NUMBER		
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE / EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
MEMIC Christopher Young 603-314-0621	2026 TO 2027 CHECK IF APPROPRIATE ☐ SELF INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
	3102900309	

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: M MALE; F FEMALE; U UNKNOWN	MARITAL STATUS: U UNMARRIED SINGLE/DIVORCED; M MARRIED; S SEPARATED; K UNKNOWN	OCCUPATION/JOB TITLE EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

RATE PER:	☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?	☐ YES ☐ YES ☐ NO ☐ NO

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	☐ AM ☐ PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE ( ) CANNOT BE DETERMINED	☐ AM ☐ PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS	PART OF BODY AFFECTED
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO	TYPE OF INJURY/ILLNESS CODE	PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?	☐ YES ☐ YES ☐ NO ☐ NO

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

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EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

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EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

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