RIVERVIEW
SCHOOL DISTRICT

Dr. Neil English, Superintendent, Ext. 4080
Ms. Sheila R Lubert, Business Manager, Ext. 4020
Dr. Christina Monroe, Director of Special Education, Ext. 4070
Dr. David Zolkowski, Elementary Schools Supervisor, Ext. 2021

July 8, 2024

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 last 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)
NOTICE TO ALL EMPLOYEES TRAINING CONFIRMATION

PLEASE READ CAREFULLY
The information below describes your duties if you are injured at work.

IN CASE OF WORK-RELATED INJURY OR DISEASE

1. The employee has the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for ninety (90) days from the date of the first visit to a designated provider.
2. The employee has the right to have all reasonable medical/surgical services and supplies, orthopedic appliances, and prostheses including required training in their use, related to the injury, paid for by the employer.
3. The employee has the right, during the ninety (90) day period to switch from one health care provider on the list to another provider on the list, and that all of the treatment shall be paid for by the employer.
4. The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider and the employer shall pay for the treatment rendered by the referral provider.
5. The employee has the right to seek emergency medical treatment from any provider but that subsequent, non-emergency treatment shall be by a designated provider for the remainder of the ninety (90) day period.
6. The employee has the right to seek treatment or medical consultation from a non-designated provider during the ninety (90) day period, but that these services shall be at the employee's expense for the applicable ninety (90) day period.
7. 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 be followed 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 provides 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.
8. The employee has the right to seek treatment from any health care provider after the ninety (90) day period has ended, and that treatment shall be paid for by the employer if it is reasonable and necessary. After ninety (90) days from the date of the first treatment, the employee shall have the duty to notify the employer of treatment by a non-designated provider within five (5) days of the first visit to the provider. The employer shall not be required to pay for treatment or services rendered by a non-designated provider prior to receiving this notification, if such services are determined, through utilization review, to have been unreasonable or unnecessary.
9. Written notice to an employee of the employer's/employee's rights and duties will be provided at time of training/hire and immediately after the injury or as soon thereafter as possible under the circumstances of the injury.
10. An employee may not refuse to sign an acknowledgement in order to avoid any duties specified in this notice.

I acknowledge that my employer has developed a list of at least six (6) panel providers. I understand that following a work-related injury or illness, I am required to visit one of the physicians or health care providers designated by my employer for the initial 90 days of treatment (Day 1 begins on the day of my first medical appointment). I understand that if I do not comply with this requirement, my employer will not be required to pay for any medical services I receive during this period. I also understand that after 90 days, I can treat with any other physician or provider of my choosing, provided I notify my employer within five (5) days of my first visit. If I fail to do so, my employer may be relieved from paying for these services if they are deemed to be unreasonable or unnecessary. My employer has informed me in writing of my rights and duties pertaining to the Pennsylvania Workers' Compensation Act. My signature below acknowledges that I have been so informed and that I understand my rights and duties.

Employee's Signature: _____ Date: _____

Witness's Signature: _____

Oakmont, PA 15139

Workers' Compensation Program: Designated Health Care Providers

The following procedures 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. Supervisors must promptly report injuries to the appropriate personnel office.

B. **Obtain medical care from a provider listed below.**

†Concentra Medical Center
Urgent Care
15 Freeport Rd Ste. 100
Pittsburgh, PA 15215
412-784-1678

†MedExpress
Urgent Care
50 Freeport Rd Ste 500
Pittsburgh, PA 15215
412-782-3278

MedExpress
Urgent Care
6510 State Route 30
Jeanette, PA 15644
724-527-3428

MedExpress
Urgent Care
3876 State Route 30
Latrobe, PA 15650
724-537-5064

Greater Pittsburgh Orthopaedic Associates
Orthopedics
5820 Centre Ave.
Pittsburgh, PA 15206
412-661-5500

Allegheny Orthopaedic Associates
Orthopedics
Locations in: Wexford, Pittsburgh
Cranberry Twp, McKees Rocks, For location nearest to you
Please call:
877-660-6777

Assocs In Neurology of Pittsburgh
Neurology
665 Rodi Rd Ste 103
Pittsburgh, PA 15235
412-466-3111

† Flynn Chiropractor Services
Chiropractic
229 Delaware Ave
Oakmont, PA 15139
412-828-8700

† Chiropractic Health Center
Chiropractic
2300 Cedar Ave
Latrobe, PA 15650
724-537-5200

† Align Chiropractic Wellness Center LLC
Chiropractic
440 Pellis Rd Ste 7
Greensburg, PA 15601
724-834-5600

Optum
Available at any major pharmacy
PHARMACY
800-393-1398

Heads Up
For the nearest location, please call the toll free number.
DENTIST
855-443-9872

One Call Medical Diagnostics
Requires adjuster approval
DIAGNOSTICS
866-672-3064

One Call Care
Requires adjuster approval
PHYSICAL THERAPY
866-672-3064

Hospital
For Emergency Services, please go to the nearest hospital.
HOSPITAL
(FOR EMERGENCY SERVICES ONLY)

C. **Medical Emergency:**
If you are faced with a medical emergency, you may secure initial emergency treatment from any of the above mentioned emergency facilities or any other emergency facility. However, any follow-up care to the emergency treatment must be with a designated health care provider.

D. **If you choose to treat with an out of state provider, you may be subject to balance billing.**

E. **For medical treatment to be paid by your employer:**
1. You must select one of the physicians or physician groups listed above.
2. You must continue to visit one of the physicians 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 physician or you may choose to go to another physician or health care 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. Your bills will be paid if your physician or healthcare provider reports as required (within ten days after your first visit and at least once a month as long as treatment continues). You must notify the new provider that these reports are to be submitted to the following address:

AmTrust North America
P O Box 94405
Cleveland, OH 44101
888-239-3909 Toll Free
678-258-8399 Fax

***For medical groups, all providers are eligible to render medical services.**

ACORD WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER / ADMINISTRATOR CLAIM NUMBER *	REPORT PURPOSE CODE *
Riverview School District 701 10th Street Oakmont PA 15139	JURISDICTION * / JURISDICTION LOG NUMBER *	
	INSURED REPORT NUMBER / OSHA CASE NUMBER	
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	LOCATION #:
INDUSTRY CODE: School / EMPLOYER FEIN: 25-1213544		PHONE #: 412-828-1800

CARRIER / CLAIMS ADMINISTRATOR

CARRIER (NAME AND ADDRESS)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME AND ADDRESS)
AmTrust North America PO Box 94405 Cleveland OH 44101	07-01-2024 TO 06-30-2025	
PHONE (A/C, No, Ext): 888-239-3909	CHECK IF APPROPRIATE: ☐ SELF INSURANCE	PHONE (A/C, No, Ext):
CARRIER FEIN *	POLICY / SELF-INSURED NUMBER: SWC1502490	ADMINISTRATOR FEIN *
AGENT NAME:	AGENT CODE NUMBER:	

EMPLOYEE / WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: ☐ MALE ☐ FEMALE ☐ UNKNOWN	MARITAL STATUS: ☐ UNMARRIED/SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN	OCCUPATION / JOB TITLE	
E-MAIL ADDRESS:			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE *	

RATE PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:	AVERAGE WEEKLY WAGES	# DAYS WORKED / WEEK	FULL PAY FOR DAY OF INJURY? (Y / N) ☐ DID SALARY CONTINUE? (Y / N) ☐

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	TYPE OF INJURY / ILLNESS	PART OF BODY AFFECTED
PHONE (A/C, No, Ext):		
DID INJURY / ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? (Y / N) ☐	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? (Y / N) ☐ WERE THEY USED? (Y / N) ☐

PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)	HOSPITAL OR OFFSITE TREATMENT (NAME & ADDRESS)	INITIAL TREATMENT
		☐ NO MEDICAL TREATMENT ☐ MINOR: BY EMPLOYER ☐ MINOR CLINIC / HOSP ☐ EMERGENCY CARE ☐ OVERNIGHT HOSPITALIZATION ☐ FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED
WITNESS NAME:	WITNESS NAME:	
PHONE (A/C, No, Ext):	PHONE (A/C, No, Ext):	

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

Applicable in Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Applicable in Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Applicable in Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in Arkansas: Any person or entity who willfully and knowingly makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who willfully and knowingly employs any device, scheme or artifice, for the purpose of obtaining any benefit or payment, defeating or wrongfully increasing or wrongfully decreasing any claim for benefit or payment, or obtaining or avoiding workers compensation coverage or avoiding payment of the proper insurance premium, or who aids and abets for any of said purposes, under this chapter will be guilty of a Class D felony.

Applicable in California: Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

Applicable in Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Applicable in the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in Florida: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information, commits insurance fraud, punishable as provided in s. 817.234.

Applicable in Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

Applicable in Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicable in Louisiana:
Applicable in Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Be advised failure to answer truthfully may result in forfeiture of workers compensation benefits.

Applicable in Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Applicable in Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

EMPLOYEE SIGNATURE: _____

Applicable in Michigan: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in Minnesota: Any person who, with intent to defraud, receives workers' compensation benefits to which the person is not entitled by knowingly misrepresenting, misstating, or failing to disclose any material fact is guilty of theft and shall be sentenced pursuant to s 609.52, subdivision 3.

Applicable in Nevada: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a category D felony.

Applicable in New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Applicable in New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicable in Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicable in Oklahoma: Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of:
1. obtaining any benefit or payment,
2. increasing any claim for benefit or payment, or
3. obtaining workers' compensation coverage under this act, shall be guilty of a felony punishable pursuant to Section 1663 of Title 21 of the Oklahoma Statutes.

Applicable in Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

Applicable in Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Utah: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicable in Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Applicable in West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

EMPLOYEE SIGNATURE: _____

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN FIELDS MARKED *

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.

OSHA CASE NUMBER:

Transfer the case number from the OSHA 300 log after you record the case there.

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 deigned 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.

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