RIVERVIEW
SCHOOL DISTRICT

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

September 13, 2023

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 for 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

NOTICE TO EMPLOYEES
RIVERVIEW SCHOOL DISTRICT

CM Regent Insurance Company, Workers' Compensation Division, the claims administrator for the school district's workers' compensation carrier, has required that we post the following list of health care providers in accordance with Section 306 of the Workers' Compensation Act.

IN CASE OF A WORK-RELATED INJURY

1. In order to ensure that your medical treatment will be paid for by your employer, or the insurance company, you must select from one of the licensed physicians or practitioners of the healing arts listed.
2. You must continue to visit one of the listed providers for ninety (90) days from the date of your first visit. If you do not comply with this requirement, your employer will be relieved from liability for payment of services rendered during this period.

DESIGNATED PHYSICIANS

See Reverse Side

You recognize and agree that your employer has posted a list of at least six (6) health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated care organizations (CCO). You also acknowledge that you have been presented with this written notice setting forth your rights and duties under Section 306(f.1)(1)(I) of the Pennsylvania Workers' Compensation Act. Your rights and duties include the following:

1. I have 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 first visit to a designated provider.
2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer.
3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment.
4. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider.
5. I have the right to seek emergency medical treatment from any provider, but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period.
6. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand my employer is not responsible to pay for these services.
7. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider, and my employer must pay for such treatment if it is reasonable and necessary.
8. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so, my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and
9. If the designated provider recommends invasive surgery, I am entitled to receive an additional opinion from any health care provider of my choice. If the additional opinion differs from that of the designated provider, I am entitled to select which course of treatment to follow. However, if I choose to follow the recommendation of my health care provider (the additional opinion), the treatment shall be performed by one or more of the designated health care providers for a period of ninety (90) days from the date of the visit to my health care provider (date of examination of the additional opinion).

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and understand my rights and duties.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

_____ EMPLOYEE'S NAME (PLEASE PRINT)

_____ DATE

_____ WITNESS

Jun-23

RIVERVIEW SCHOOL DISTRICT
DESIGNATED PHYSICIANS

MEDICAL PROVIDER	ADDRESS	PHONE	SPECIALTY
Concentra Medical Center	15 Freeport Road Suite 100 Pittsburgh, PA 15215	412-784-1678	Occupational Health
MedExpress Urgent Care Ohara Township	50 Freeport Road Suite 500 Pittsburgh, PA 15215	412-782-3278	Occupational Health
MedExpress Urgent Care	6510 State Route 30 Jeannette, PA 15644	724-527-3428	Occupational Health
MedExpress Urgent Care Latrobe	3876 State Route 30 Latrobe, PA 15650	724-537-5064	Occupational Health
Greater Pittsburgh Orthopedic Assoc.	5820 Centre Ave. Pittsburgh, PA 15206	412-661-5500	Orthopedics
Allegheny Orthopedic Associates (EXCLUDING: Dr. Patrick Ward) Locations In: Wexford, Cranberry Shoppes and West Penn Hospital	For location nearest to you, please call	877-660-6777	Orthopedics
Associates in Neurology	665 Rodi Road, Ste. 103 Penn Hills, PA 15235	412-241-7380	Neurosurgery
Flynn Chiropractor Services	229 Delaware Ave. Oakmont, PA 15139	412-828-8700	Chiropractic
Chiropractic Health Center	2300 Cedar Ave. Latrobe, PA 15650	724-537-5200	Chiropractic
Align Chiropractic Wellness Center	440 Pellis Road Suite 7 Greensburg, PA 15601	724-834-5600	Chiropractic
S1 Medical	Call toll free for location nearest you	888-945-5055	Diagnostic studies/PT/OT, Home Health, DME
Corvel	For prescriptions, please call	800-563-8438	Pharmacy

UPDATED: 08-21

CM REGENT™
INSURANCE COMPANY

Workers' Compensation Division

Internal School District Work-Related Incident Report

Section One: Employee and Incident Information

Employer Name:	Employer Address:	County:
Employee Name (last, first, initial):	Home Phone #:	Gender: M ☐ F ☐ / Marital Status: M ☐ S ☐ D ☐ W ☐
Home Address (street, city, state, zip code):		County:

Social Security #:	DOB:	Date of Incident:	Time of Incident:	Date Reported:	To Whom Reported:	Start Time:

Location of Incident (building, room, etc.):	Type of Injury (cut, sprain, etc.):
Injured Body Part:	Cause of Injury (machine, tool, equipment, liquid, etc.):

Employee's Job Title:	Hours Worked Per Week:	Name of Witness(es):

Description of Incident (please describe in detail what happened):

Employee Name:	Employee Signature:	Date:
Employee's Supervisor Name:	Employee's Supervisor's Signature:	Date:

Section Two: No Medical Treatment

☐ Returned to Work ☐ Returned to Work with Modified Duties ☐ Sent Home

Supervisor's Signature: Date:

Section Three: Medical Treatment or First Aid

Type of Injury: _____ ☐ New ☐ Other (describe): _____

Treatment/First Aid: _____

Diagnosis: _____

Disposition: _____

☐ Return to work without limitations

☐ Return to work with limitations (describe): _____

☐ May return to work on: _____

☐ Follow-up appointment with: _____ on _____

Signature of medical/first aid provider _____ **Date:** _____

Medical Facility Address:

300 Sterling Parkway, Suite 100, Mechanicsburg, PA 17050
844-480-0709 Fax: 866-402-6601 www.CMRegent.com