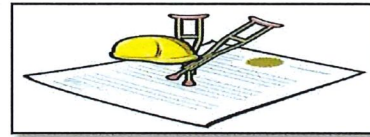
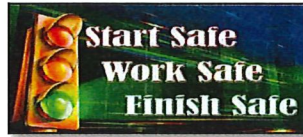


2022-2023

WELCOME BACK



SAFETY/WORK INJURY INFORMATION

Enclosed are the following information pages:

- 1) Notice to All Employees
- 2) Updated Safety Committee Membership List
- 3) Panel of Physicians (For Work Injury Treatments)
- 5) Other information
- 6) Workers' Compensation Information

After reading please return the Workers' Compensation Information form, filled in and dated. The Workers' Compensation Information form is the only page that needs returned to Amy Ellis, Central Office, by September 15, 2022. **Keep all other paperwork for your file and future reference.**

All work related injuries need to be reported to your supervisor/principal and Amy Ellis-Workman's Comp Coordinator within 24 hours of your injury. The proper paperwork then needs to be completed and submitted to Amy Ellis. The forms are all online on our website-rasd.us (staff-employee **Forms-incident/accident investigation report-work injury packet**). If a work injury occurs, you need to submit the work injury report with complete and detailed information **and the employment notification and acknowledgement** page (signed, witnessed and dated) to Amy Ellis. Paperwork must be complete and handed in quickly so that a report can be submitted to the insurance company. Delays may cause your claim to be denied.

HAVE A SAFE AND HAPPY SCHOOL YEAR!

July 27, 2022

NOTICE TO ALL EMPLOYEES

In the case of a work related injury, the following procedures should be observed:

1) If needed, seek medical attention from one of the medical facilities listed on the Panel of Physicians.

2) All occupational injuries must be reported to your supervisor/principal and Amy Ellis-Workman's Comp Coordinator within 24 hours of your injury. The attached work injury report form should be used. Timely reporting of work related injuries can expedite your claim.

3) Provide Amy Ellis-Workman's Comp Coordinator with doctor note/reports immediately, should you be disabled from work. (Doctors reports are required prior to receiving workers' compensation benefits).

Your employee contact person for claim information is Amy Ellis-Workman's Comp Coordinator.

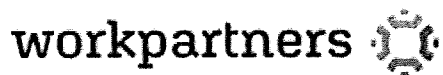
Your insurance company for claims is:

WorkPartners Claims Management Services
P.O. Box 2971
Pittsburgh, PA 15230
1-800-633-1197

IMPORTANT NOTE: Your employer reserves the right to request a second opinion prior to authorizing payment of any surgery (except for emergency situations). Prior to scheduling any surgery, please contact WorkPartners Claims Management Services at the above phone number.

RIDGWAY AREA SCHOOL DISTRICT
SAFETY COMMITTEE MEMBERSHIP LIST
2022-2023

NAME	JOB TITLE	WORKPLACE AND ADDRESS	ADMIN REP	EMPLOYEE REP
JIM DELHUNTY	DIRECTOR OF BUILDING AND GROUNDS	62 SCHOOL DRIVE, RIDGWAY, PA 15853	X	
DONNA SIDELINGER	BUSINESS MANAGER	62 SCHOOL DRIVE, RIDGWAY, PA 15853	X	
PAM YEAGER	ELEMENTARY PRINCIPAL	62 SCHOOL DRIVE, RIDGWAY, PA 15853	X	
SHAWN HOFMANN	VICE PRINCIPAL	1403 HILL STREET, RIDGWAY, PA 15853	x	
JANIE SKRABA	TECHNOLOGY AIDE	1403 HILL STREET, RIDGWAY, PA 15853		X
AMY ELLIS	SECRETARY/WORKER'S COMP COORDINATOR	62 SCHOOL DRIVE, RIDGWAY, PA 15853		X



August 18, 2022

Ridgway Area School District
Ridgway, PA 15853

Dear Valued Workpartners Policy Holder,

Thank you for choosing Workpartners for your workers' compensation program. As part of our services, we have enclosed your workers' compensation provider panels developed for your workplace locations to be utilized for work-related injuries sustained from your policy effective date and going forward. In the event of a panel update, that updated listing will be effective as of the date of notice and is to be used for any work-related losses reported from that day forward.

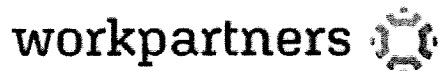
Posting of an up-to-date workers' compensation panel is a requirement under the Pennsylvania Workers' Compensation Act. You are also required to have your employees sign the Employee Rights and Duties Form, which confirms they are aware of your designated Workers' Compensation Provider Panel. This signature is required at time of hire/establishment of new panel and after an injury is reported. For your convenience, we have attached a copy of the Employees Rights and Duties and Employee Acknowledgement forms.

Please confirm your receipt and agreement to post the attached workers' compensation panels at your designated workplace location(s). In order that a panel is available for your employees as quickly as possible, we look forward to hearing your feedback within five (5) calendar days. After that time period we will accept the panel as approved by you, in the absence of a response.

If you have any questions or requests regarding your panel creation, please contact WCPanels@upmc.edu. We appreciate the opportunity to partner with you.

Sincerely,

Workpartners Panel Management Team



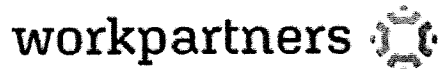
Ridgway Area School District - Ridgway (15853)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
Send Bills To: PO Box 2971, Pittsburgh, PA 15230
Fax: (412) 454-8717
To Report a Claim Call: 1-800-633-1197
WC Policy:WC200-2030907
Policy Effective Date:07/01/2022

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
Workplace Health - Brookville	231 Allegheny Blvd, Ste D Brookville, PA 15825	814-715-7471	Occupational Medicine
*UPMC Kane Occupational Medicine	4372 US Rte 6 Kane, PA 16735	814-837-4793	Occupational Medicine
Fernan Family Practice	200 S Mill St Ridgway, PA 15853	814-772-0722	Family Practice
Penn Highlands QCare Walk-In Clinic - Ridgway	104 Metoxet St, Ste A Ridgway, PA 15853	814-772-8122	Urgent Care
Penn Highlands General Surgery - Ridgway	123 South St Ridgway, PA 15853	814-772-2485	General Surgery
Western Pennsylvania Neurosurgical Associates	100 Medical Arts Bldg, Ste 130 Kittanning, PA 16201	724-543-3550	Neurosurgery
Penn Highlands Orthopaedics & Sports Medicine - DuBois	145 Hospital Ave, MAB, Ste 311 DuBois, PA 15801	814-299-7432	Orthopedics
*Champion Orthopedics & Sports Medicine at UPMC - Coudersport	1001 E Second St UPMC Cole Coudersport, PA 16915	814-274-5320	Orthopedics
Elk County Eye Clinic	765 Johnsonburg Rd Saint Marys, PA 15857	814-781-3435	Ophthalmology
One Call Physical Therapy	Call Toll-Free for Closest Location	1-844-284-2525	Physical Therapy
One Call Chiropractic	Call Toll-Free for Closest Location	1-844-284-2525	Chiropractic
One Call Imaging Services	Call Toll-Free for Closest Location	1-844-284-2525	Diagnostic Imaging
One Call Durable Medical Equipment	Call Toll-Free for Supplier	1-844-284-2525	DME

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.



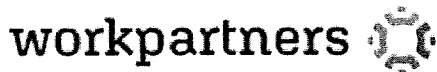
Ridgway Area School District - Ridgway (15853)
YOUR WORKERS COMPENSATION CLAIMS ARE MANAGED BY WORKPARTNERS
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NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers.
3. You must continue to visit one of the physicians listed below, if you need treatment, for ninety (90) days from the date of your first visit.
4. If one of the persons below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
5. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth below, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
6. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physicians opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer-designated provider for up to 180 days.
7. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work-related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Scheduling</u>	<u>Area of Specialty</u>
myMatrixx (an Express Scripts company)	Call Toll-Free for Closest Location BIN# 003858, Group# KYHA	1-800-945-5951	Pharmacy

*In accordance with Section 306(f.1)(1)(i) of the Worker's Compensation Act AND 34 Pa. Code Section 127.753 Disclosure Requirements, this health care provider is employed, owned or controlled by UPMC.



**EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER
SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKER'S COMPENSATION ACT**

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

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

Employee's Signature _____ Date _____

Employee's Name (Print)	Employee Number
-------------------------	-----------------

Employer	Department
----------	------------

Witness' Signature _____ Date _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.

Ridgway Area School District

WORK INJURY REPORT FORM

What is the Purpose of the Form?

This form is to be used when any type of injury occurs in any way within the school district.

Who Should File the Form?

Any school employee who is injured within the district.

When Should the Form be Filed?

The form should be filed within 24 hours of the incident.

Special Notes:

The Work Injury Report Form, the Employment and Notification Acknowledgement page (signed, witnessed and dated). Included for your informational needs are the Panel of Doctors you must use for the first 90 days, the Notice to all Employees for important general information and a listing of the Safety Committee Members. **The Incident Investigation report is only for the person who will be investigating the circumstances and cause of any incident that occurs. The injured person does not complete this form.**

ALL INFORMATION SHOULD REMAIN CONFIDENTIAL AT ALL TIMES.

Revised: 1/8/15

RASD
WORK INJURY REPORT FORM

RASD

(IT IS VERY IMPORTANT THAT YOU COMPLETE ALL INFORMATION IN ITS ENTIRETY)

NAME OF INJURED EMPLOYEE: _____

SOCIAL SECURITY NUMBER: _____

BIRTHDATE: _____ **MARITAL STATUS:** _____

ADDRESS: _____

HOME PHONE: _____ **DATE AND TIME OF INJURY:** _____

WHAT WAS EMPLOYEE DOING AND HOW DID THE INJURY OCCUR?

DESCRIBE IN DETAIL THE EXACT LOCATION OF THE INJURY ON THE BODY AND THE TYPE OF INJURY RECEIVED.

WAS MEDICAL ATTENTION RECEIVED, WHERE AND BY WHOM (GIVE DR.'S NAME AND FACILITY WHERE TREATED, ALSO DATE AND TIME OF INITIAL APPOINTMENT)?

OCCUPATION AND IF FULL-TIME OR PART-TIME: _____

WAS SAFETY EQUIPT. PROVIDED? _____ WAS SAFETY EQUIPT. USED? _____

HAVE YOU HAD ANY PREVIOUS WORK INJURIES? _____

DO YOU WORK ELSEWHERE? _____

NORMAL STARTING TIME: _____

EMPLOYEE SIGNATURE: _____

WITNESS SIGNATURE AND PHONE NUMBER: _____

YOU ARE STILL REQUIRED TO CALL THE ADMINISTRATION OFFICE AS SOON AS POSSIBLE AFTER YOUR ACCIDENT.

ALL INFORMATION SHOULD REMAIN CONFIDENTIAL AT ALL TIMES.



WORKERS' COMPENSATION INFORMATION

To All Employees:

The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

Benefits are required to be paid by your employer if self-insured, or through insurance provided by your employer. Your employer is required to post the name of the company responsible for paying workers' compensation benefits at its primary place of business and at its sites of employment in a prominent and easily accessible place. It is also required to be posted in any areas used for treatment of injured employees or for the administration of first aid.

You should report immediately any injury or work-related illness to your employer. Your benefits could be delayed or denied if you do not notify your employer immediately.

If your claim is denied by your employer, you have the right to request a hearing before a Workers' Compensation Judge.

The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information:

Bureau of Workers' Compensation
1171 South Cameron Street, Room 103
Harrisburg, Pennsylvania 17104-2501
Telephone No. within Pennsylvania: 1-800-482-2383
Telephone No. outside of this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____, employee of _____,
(employer)

certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Fax this form to Workpartners (412-454-8717) if it is being completed as a result of a work injury; then place the original in the employee file. If this form is being completed for any reason other than in conjunction with an injury please do not fax to Workpartners, only place in the employee file.