The ODLE Way:
Opportunities for Growth
Dedicated to Those We Serve
Loyalty to a High Performing Workforce
Excellence in All We Do

EMPLOYEE ACCIDENT REPORT

Employer: **Odle Management/(location address)** 7175 Highland Drive, Pittsburgh, PA 15206

Employee Name: _____

Incident Date/time: _____

Incident(exact)Location: _____

What happened? (Please describe accident in your own words):

_____

_____

_____

_____

How were you injured? _____

_____

What part(s) of your body was/were hurt? (Indicate Right or Left)

_____

Have you ever injured this part of your body before? (Yes/No) If so, please describe:

_____

_____

Who was present when the accident happened?

_____

The above report is true and correct:

_____ _____

Signature Date

Accident Reports must be handed in to your supervisor or acting supervisor immediately after any incident. Failure to promptly report accidents will result in discipline up to and including discharge.

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WITNESS STATEMENT

(To be completed by the witness)

Name of Injured Employee:_____ Date of Injury:_____

Name of Witness:_____ Phone Number:_____

Address of Witness:_____

Witness to accident or injury to answer all of the following questions:

1. Did you witness the accident or injury? ☐ YES NO ☐
2. What part(s) of the body was injured? (head, neck, back):

   _____
3. Describe the type injury (strain, bruise, laceration):

   _____
4. What did the injured employee say at the time of the injury?

   _____
5. Did the injured employee complain of pain? If so, where?

   _____
6. Explain what the employee was doing at the time of the accident or injury occurred:

   _____

   _____

   _____

   _____

The above statement is true and correct:

_____ _____

Signature of Witness Date

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties.

Berkshire Hathaway HOMESTATE COMPANIES

Pittsburgh, PA

NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted below for you to review. Also, you may get a copy of this list from HR.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury of illness if you expect your employer to pay for the medical treatment you receive.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- If you seek treatment for your work injury of illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for the treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties.
If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT [*Check one*]:
☐ TIME OF HIRE ☒ WHEN I WAS INJURED ☐ OTHER

EMPLOYEE: _____ **DATE:** _____

EMPLOYER REPRESENTATIVE: _____ **DATE:** _____

Providers, All
MedExpress Urgent Care
Occupational Medicine
50 Freeport Rd Ste 500
Pittsburgh, PA 15215
412-782-3278

Zgurzynski, Alexia M., DO
Concentra
Family Medicine
15 Freeport Rd Ste 100
Pittsburgh, PA 15215
412-784-1678

Banks, Louise, MD
MVH Occupational Health
Occupational Medicine
800 Plaza Dr Ste 210
Belle Vernon, PA 15012
724-379-1940

Rytel, Michael, MD
Greater Pittsburgh Orthopaedic Associates
Orthopedics: Sports Medicine
5820 Centre Ave
Pittsburgh, PA 15206
412-661-5500

Kann, Jeffrey, MD
Tri-State Orthopaedics
ORTHOPEDICS
300 Chapel Harbor Dr Ste 300
Pittsburgh, PA 15238
412-696-0300

Tissenbaum, Allan, MD
The Orthopedic Group
ORTHOPEDICS
1145 Bower Hill Rd Ste 301
Pittsburgh, PA 15243
412-279-7022

(OVER)

WORKERS' COMPENSATION INFORMATION

- 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 when 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, including, without limitation, areas used for the 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 at:

Bureau of Workers' Compensation
1171 South Cameron Street,
Room 103,
Harrisburg, Pennsylvania 17104-2501
Telephone number within Pennsylvania (800) 482-2383
Telephone number outside of this Commonwealth (717) 772-4447
TTY (800) 362-4228 (for hearing and speech impaired only)
www.state.pa.us, PA Keyword: workers comp

I have read this document and fully understand its entire contents. I have asked questions about anything that was not clear to me and I am satisfied with the answers I have received. I understand that I have a right to receive a copy of this acknowledgment upon my request.

_____
Employee Name

_____
Employee Signature

_____
Date

34 Pa. Code § 121.3b

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SUPERVISOR'S ACCIDENT REPORT

Employee Name: _____

Employee SSN: _____ Date Reported: _____

Employee DOB: _____ Time Reported: _____

Employee Dependents/Rate of Pay/Marital Status/Date of Hire: _____

Date of Incident: _____

Time of Incident: _____

Location and brief description of incident: _____

Did the employee report the incident immediately? YES ☐ NO ☐

Did you or someone else witness the incident? YES ☐ NO ☐

If someone else did, who? _____

Do you have any reason to question the legitimacy of the incident? ☐ YES NO ☐

If yes, please explain: _____

_____

Indicate the conditions that led to the incident:

☐	Unused/Unavailable lifting equipment	☐	Wet/Slippery Floor
☐	Unused/Unavailable PPE (gloves, etc.)	☐	Poor Housekeeping
☐	Unused/Unavailable Sharps Container	☐	Interaction with co-worker
☐	Unguarded Equipment	☐	Interaction with resident
☐	Electrical	☐	Chemical Exposure
☐	Obstructed View	☐	Airborne Contaminants/Smoke
☐	Lack of Training	☐	Other
☐	Defective Tools or Equipment	☐	

What changes could be made to eliminate or reduce the hazard(s) identified above?

_____

_____

_____

_____ _____ _____

Prepared by Title Date

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Employee Refusal of Medical Treatment

This form is to be completed by any employee who refuses medical treatment for a work-related injury/illness. Pleases forward the completed form, along with the Supervisor's Report of Work-Related Injury to Human Resources.

I,_____have been encouraged by my supervisor and/or a representative of Odle Management to seek medical treatment for the following injury/Illness, and I am refusing medical treatment at this time. The injury/illness occurred on_____(date).

Description of Injury/Illness: _____

_____

_____

How did it occur?_____

_____

_____

I understand that if I choose to seek medical treatment in connection with this incident and/or suffer any lost time away from work, I must contact Human Resources immediately for the name and address of the clinic that is authorized to treat me.

_____ _____

Employee's Signature Date

_____ _____

Supervisor's Signature Date