

Workers' Compensation Claims Report

School Claims Service, LLC

P.O. Box 813
New Cumberland, PA 17070-0813
Tel: (866) 402-6600
Fax: (866) 402-6601

In life-threatening situations, immediately seek medical assistance, then complete this claim form!

All work-related incidents must be promptly reported to your school district workers' compensation coordinator who will assist you in completing this form.

Directions for completion of these forms:

The school district's workers' compensation coordinator will assist you in completing Section One of the Work-Related Incident Report – a complete, detailed description of what happened is essential. The supervisor and the claimant should complete the Incident Investigation Report.

- The Workers' Compensation Coordinator will immediately fax Copy A of the Work-Related Incident Report to School Claims Service, LLC, at (866) 402-6601 **WITHIN 24 HOURS OF THE INJURY**. Copy B and C will be given to the employee for appropriate signatures and returned to the Workers' Compensation Coordinator.
- If medical treatment is required, the employee will be given a copy of the Designated Physician List (if applicable). After medical treatment is rendered, the employee shall report back to the Workers' Compensation Coordinator with all the forms. The medical provider will have completed and signed the medical treatment section.
- Based on the medical provider's direction, the employee shall return to work on full or modified duty or follow the instructions for additional medical treatment.

Note: Copy B and C of the Work-Related Incident Report are to be taken to the medical provider – Copy B will be signed and returned to the employer after medical treatment and Copy C may be retained by the employee. The workers' compensation coordinator should secure a completed Incident Investigation Report from the injured employee's supervisor within 24 hours. Immediately fax all completed forms to School Claims Service, LLC, at (866) 402-6601. The employer will maintain originals of all forms. School Claims Service, LLC, will complete the LIBC344 form (Employer Report of Occupational Injury or Disease) when appropriate, and send both the employer and employee copies to the workers' compensation coordinator for distribution.

Work-Related Incident Report – School Claims Service, LLC

Section One: Employee and Incident Information

SCHOOL DISTRICT NAME (NO ABBREVIATIONS):		SCHOOL DISTRICT ADDRESS:			County:	
Employee name (last, first, middle initial):			Home phone:		Gender: M F	Marital status: M S Dep.
Home address (street, city, state, zip):					County:	
SS #:	Date of birth:	Date of incident:	Time of incident:	Date reported:	To whom reported:	
Location of incident (building, room, etc.):			Type of injury (cut, sprain, etc.):			
Injured body part:		Cause of injury (machine, tool, etc.):				
Employee's job title:		Date of hire:	Hours worked per week:		Time shift starts:	
Description of incident (please describe in detail what happened):						
Name of supervisor: _____						

Section Two: Medical Authorization

I, the undersigned, hereby authorize any medical care provider who has treated me, or any hospital to which I have been admitted, to furnish to any authorized representative of School Claims Service, LLC, any and all information which may be requested regarding my physical condition, treatment or disease, and if necessary, to allow them or any physician appointed by them to review any X-rays or records, regarding my physical condition or treatment.

Employee's signature: _____ Date: _____

Section Three: For Use of School District's Workers' Compensation Coordinator

TYPE OF CLAIM: Notice Only (No Medical Treatment) Medical Only Lost time/Last date worked ____/____/____

NAME OF W/C COORDINATOR: _____ **Phone:** _____ **Ext.:** _____

DO NOT WRITE IN THIS AREA

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FAX TO SCHOOL CLAIMS SERVICE, LLC WITHIN 24 HOURS OF INJURY

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Section One: Employee and Incident Information

SCHOOL DISTRICT NAME (NO ABBREVIATIONS):		SCHOOL DISTRICT ADDRESS:		County:	
Employee name (last, first, middle initial):			Home phone:	Gender: M F	Marital status: M S Dep.
Home address (street, city, state, zip):					County:
SS #:	Date of birth:	Date of incident:	Time of incident:	Date reported:	To whom reported:
Location of incident (building, room, etc.):			Type of injury (cut, sprain, etc.):		
Injured body part:		Cause of injury (machine, tool, etc.):			
Employee's job title:		Date of hire:	Hours worked per week:	Time shift starts:	
Description of incident (please describe in detail what happened):					
Name of supervisor: _____					

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Employee's signature: _____ Date: _____

Section Three: For Use of School District's Workers' Compensation Coordinator

TYPE OF CLAIM: Notice Only (No Medical Treatment) Medical Only Lost time/Last date worked ____/____/____

NAME OF W/C COORDINATOR: _____ **Phone:** _____ **Ext.:** _____

Section Four: Medical Treatment

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

Treatment/first aid: _____

Diagnosis: _____

Disposition: _____

Return to work without limitations
 Return to work with noted limitations (describe): _____
 May return to work on ____/____/____
 Followup appointment with: _____ on ____/____/____

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

Address: _____

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Location of incident (building, room, etc.):			Type of injury (cut, sprain, etc.):		
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Employee's signature: _____ Date: _____

Section Three: For Use of School District's Workers' Compensation Coordinator

TYPE OF CLAIM: Notice Only (No Medical Treatment) Medical Only Lost time/Last date worked ____/____/____

NAME OF W/C COORDINATOR: _____ Phone: _____ Ext.: _____

Section Four: Medical Treatment

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

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Incident Investigation Report

(To be conducted by the supervisor with the employee)

Note: The information provided in this report will be used to promote a safer working environment for all employees by identifying unsafe work practices or conditions. The contents of this report will not be used to criticize or penalize any employees injured on the job.

PLEASE PRINT

Employee name _____ Date of injury _____

Employer name _____

1. Describe the basic cause(s) of the incident (what *specific factor(s)* caused the incident – what was the employee doing, how was the activity being carried out and what machinery, equipment, tools or objects were involved):

- 2. Would you describe this incident being the result of: work practice work environment both
- 3. Was personal protection equipment or guards provided for this activity? yes no
- 4. Was the personal protection equipment or guards being used at the time? yes no
- 5. Should personal protection equipment or guards be provided for this activity? yes no
- 6. Are there safety rules that apply to this activity? yes no
- 7. How could this incident have been prevented?

8. Describe the resulting injuries:

9. Witnesses:

Name	Phone (day)	Phone (evening)
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Explain in detail what actions could be taken to correct the unsafe act or condition.

11. Who is responsible for implementing the corrective action and when do you anticipate it will be accomplished?

Supervisor signature _____ Date _____

Note: Fax a copy of this report and the Work-Related Incident Report to School Claims Service, LLC, at (866) 402-6601, as soon as possible.