	HEMPFIELD FIRE DEPARTMENT – ADMINISTRATIVE			
	100.6 – FIREFIGHTER INJURY REPORTING			
	ISSUED:	**January 25, 2021**	**REVISED:**	

PURPOSE:

The purpose of this policy is to establish the procedure for reporting Injuries sustained by to Hempfield Township insured firefighters.

SCOPE:

This standard operating policy shall apply to all Hempfield Township firefighters.

ENFORCEMENT:

The Fire Chief and all Hempfield Fire Department Officers are ultimately responsible for ensuring the safety of firefighters in Hempfield Township. Any person deviating from this policy may be required to submit, in writing, an explanation for deviating from this policy to the Fire Chief within five days.

GENERAL:

1. Each member will be given a copy of the designated workers' compensation provider list.

2. If a firefighter is injured during activities approved by Chapter 47 of Hempfield Township Municipal Code, it is his or her responsibility to immediately report the injury to the officer in charge at the time the injury occurs.

3. The member must complete a firefighter injury report form. This form shall be submitted to the Hempfield Fire Department Fire Chief within 24 hours. Incomplete forms can cause a delay in the processing of any claim.

4. The station captain/chief has the ultimate responsibility to report all firefighter injuries to the township; and, shall ensure that all documentation for the injured firefighter is forwarded to the township.

5. In the case of an emergency, the member may be taken to any of the emergency facilities listed on the Township Workers' Compensation Physicians List. In the case of any work-related injury or disease, and in accordance with the Pennsylvania Workers' Compensation Act, the member has the duty to obtain treatment from one or more of the health care providers designated by Hempfield

Township (see Attachment A) for 90 days commencing on from the date of the first visit to a designated provider. The list of designated providers shall be posted in each fire station in an area where all members have access.

PROCEDURE:

1. In the event of a firefighter injury, the highest-ranking firefighter on the scene shall ensure medical aid is provided as needed. Additional resources should be requested by the firefighter if required.

2. If the firefighter does not require medical care, an injury report form shall be filled out and forwarded to the Fire Chief for record keeping.

3. If the injury requires medical treatment, the firefighter should proceed to a care provider identified in designated workers' compensation provider list.

4. In the event that a firefighter requires further medical treatment, a firefighter should be assigned to accompany the injured party during the treatment and/or transport. This accompanying firefighter should remain with the firefighter until a family member or responsible party arrives.

5. The highest-ranking station firefighter or station officer that is on scene when the injury occurs shall notify the chief of the department.

6. The station officer shall notify the Fire Chief when the injury occurs. In the absence of the fire chief, the highest-ranking firefighter shall be responsible for the immediate notification of the township.

7. The injured firefighter should complete the injury reporting form and forward it to the officer in charge. If the injured firefighter is unable to complete the injury report form it will be the responsibility of the officer in charge to complete any documents as required.

8. Upon completion of all relevant paperwork the officer in charge shall submit all required paperwork to the Fire Chief within 24 hours after the injury if it occurs.

9. The injured member will keep the fire chief informed of the status of treatment. The fire chief will then communicate any changes to the township.

10. The incident report (when applicable) shall be completed immediately.

HEMPFIELD TOWNSHIP
724-834-7232

WHAT TO DO IN CASE OF A WORK RELATED INJURY

If you suffer a work-related injury your health and well-being are our first concern!

If your injury is of a serious nature and requires the assistance of an ambulance or rescue personnel, the appropriate emergency service providers should be contacted immediately.

However, if the injury is of a less serious nature the following procedures must be followed:

1) **Report your injury to your supervisor as soon as possible.** S/he or a designated person will provide you with the information identifying providers that have been selected on the panel specifically developed for your company.

2) **Seek initial medical attention from the providers on the list below.** As per the Workers' Compensation Act of Pennsylvania, if you are injured at work, your employer's insurer is responsible to pay for reasonable and medically necessary treatment for the reported work related injury , but only if you select a provider for your initial care from the list below:

NAME OF PROVIDER	ADDRESS	PHONE	SPECIALTY
Med Express	5126 Rte. 30, Ste. 300, Greensburg	724-836-3027	Emergency Services
Med Express	12120 Rte. 30, North Huntingdon	724-863-4362	Emergency Services
Med Express	6510 Rte. 30, Jeannette	724-527-3428	Emergency Services
Excela Hospital ER	532 West Pittsburgh St., Greensburg	724-832-4355	Emergency Services
Tri-County Occupational Med.	4000 Hempfield Plaza Blvd, Greensburg	724-925-6050	Primary Care
Excela Health Orthopedics	680 Pellis Road, Greensburg	724-689-1970	Orthopedics
Excela Health Orthopedics	133 Donohoe Road, Greensburg	724-834-4448	Orthopedics
Excela Health Orthopedics	8775 Norwin Ave., North Huntingdon	724-861-7901	Orthopedics
FHPP	870 Weatherwood Lane, Greensburg	724-838-0090	Neurology
Hartman Ophthalmic Assoc.	516 Pellis Road, Greensburg	724-836-0190	Opthalmology
Jaime P. DiAndreth	4536 Route 136; Ste. 12, Greensburg	724-830-8815	Physical Therapy
Russell Eshman, DC	600 Oak Street, Irwin	724-863-3226	Chiropractic

***KeyScripts will schedule the appointment for you at any number of participating facilities that are close to you, or for durable medical equipment and supplies will place the order so that the equipment and supplies can be obtained for you.**

Key Scripts, LLC*		1-866-446-2848	Radiology Physical Therapy Chiropractic Durable Medical Equipment
The pt Group	520 Pellis Rd., Ste. 100, Greensburg	1-866-446-2848	Physical Therapy
Jeannette Physical Therapy	1117 Lowry Ave., Bldg C., Jeannette	1-866-446-2848	Physical Therapy
Orthopedic & Sports PT Assoc.	11639 Rte. 30; Ste. 300, North Huntingdon	1-866-446-2848	Physical Therapy

Employee Acknowledgement Form

As per the Pennsylvania Workers' Compensation Act your employer has selected a "designated list of healthcare providers" who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list of designated providers (or panel) is posted in a prominent location that is accessible to all employees. In addition, your supervisor can provide you with a copy of these designated providers. If you are injured at work, 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 have all reasonable medical supplies and treatment related to the injury paid for by your employer as long as treatment is obtained from a designated provider during the 90-day period.
- √ You have the **RIGHT** to choose which of the panel providers will treat you for your work-related injury.
- √ You have the **RIGHT** during this 90-day period, to switch from one health care provider on the list to another provider on the list, and treatment shall be paid for by the employer. You have the **RIGHT** to seek treatment from the referral provider if you are referred to him by a designated provider.
- √ You have the **RIGHT** to receive emergency medical treatment from any provider, but subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period. Non-emergency treatment must be delivered by a listed panel provider.
- √ You have the **Right** to seek an additional opinion from any health care provider of your choice when a designated provider prescribes invasive surgery. If the additional opinion differs from the opinion of the designated provider and that opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.
- √ You have the **DUTY** to obtain treatment for work-related injuries from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- √ You have the **RIGHT** to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days

Medical Treatment: After the first 90 days

- √ You have the **RIGHT** to receive treatment from any physician or other healthcare 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-related injury and has been properly documented by the physician or other health care provider.
- √ You have the **DUTY** to notify your employer if you chose to receive treatment from a physician or other healthcare provider who is not on your employers designated panel listing of providers. You must notify your employer within five (5) days of the first visit to any provider who is not on your employer's panel listing. The employer may not be required to pay for treatment until you have given this notice. However, the employer shall pay for these services once notified, unless the treatment is found to be unreasonable.

Your signature on this form indicates that you have been informed of and 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 Signature:_____ Date: _____

Employee Name (please Print): _____

Employer Representative's Signature:_____ Date: _____

HEMPFIELD TOWNSHIP BOARD OF SUPERVISORS

1132 Woodward Drive, Suite A, Greensburg, PA 15601 PHONE: 724-834-7232

SPECIAL NOTE: When injured, please present your Firefighters I.D. Card at the hospital/physician and advise them that your injury is a workmen's compensation claim and that all bills should be forwarded to the following address: **State Workers' Insurance Fund, 100 Lackawanna Ave., Scranton, PA 18503 (Acct. #05900734).** Any questions contact Denise at Hempfield Township 724-834-7232, Ext. 111.

ALL WORKMEN'S COMPENSATION CLAIMS MUST BE RETURNED TO THE TOWNSHIP WITHIN 24 HOURS OF THE ACCIDENT!!!!!

(Volunteer Fire Departments)

WORKMEN'S COMPENSATION ACCIDENT REPORT

PLEASE PRINT CLEARLY FOR ACCURATE PROCESSING:

Name of Fire Dept./Ambulance Service: _____

Name of Injured Person: _____ **Date of Report:** _____

Address: _____

Telephone No: _____ **Social Security No:** _____ **Male:** ☐ **Female:** ☐

Date of Birth: _____ **Age:** _____ **Married:** ☐ **Yes** ☐ **No** **Number of Dependents:** _____

Date of Injury: _____ **Exact Time of Injury:** _____(a.m.) (p.m.) **Time in Service:** _____

Date Joined Fire Department: _____ **Employer's Phone #** _____

Loss of Work: ☐ **Yes** ☐ **No** **First Day off Work:** _____ **Date Returned to Work:** _____

Area of body injured & Type of Injury (broken right arm, cut left hand, etc:)**:** _____

_____

Injured Party's Statement (How accident occurred. Cause of accident including exact location, street, city, county)**:** _____

_____

_____

_____

_____

All equipment, materials or chemicals used: _____

_____

At time of incident, what type of activity was the injured party involved in:

☐ **Firefighting** ☐ **Drill** ☐ **Schooling** ☐ **Other (explain)** _____

_____

Was injured party in full protective gear: ☐ **Yes** ☐ **No If no, explain:** _____

_____

Was injury a result of unsafe act and/or condition: ☐ **Yes** ☐ **No**

Attending Physician/Hospital: _____ **Date & Time:** _____

Address Physician/Hospital: _____

Signature of Injured Employee: _____ **Date:** _____

***Witness Signature:** _____ **Print Name:** _____ **Date:** _____

Witness Phone #: _____

Witness signature verifies the above statement to be true and correct

Signature of Chief or Line Officer: _____ **Date:** _____

NOTICE: PLEASE ATTACH ALL COPIES OF TREATMENT PAPERWORK.