WALLINGFORD SWARTHMORE
SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

200 SOUTH PROVIDENCE ROAD, WALLINGFORD, PENNSYLVANIA 19086-6334
PHONE (610) 892-3470 EXT. 1406, 1405, 1401 FAX (610) 892-3424

WORKERS' COMPENSATION CLAIMS REPORTING

In life-threatening situations, immediately seek medical assistance, then complete necessary forms!

All work-related incidents must be promptly reported to the school nurse and Human Resources Department through the following process.

1. **Contact your school nurse** to report the injury and obtain the workers' compensation (WC) claim forms.
2. **Call Human Resources Department** (Eileen at 610-892-3470 extension 1406) to report injury.
3. **Complete and send** the attached ***Internal School District Work-Related Incident Report*** and forms with "**to be completed by Employee**" to the Human Resources Department as soon as possible. A WC claim number cannot be assigned until the claim is submitted to the WC carrier. All notice of injuries must be made within 21 days of the injury to the employee.
4. If medical treatment is required, the employee should refer to attached ***Designated Health Care Providers*** list (panel). You must receive treatment with a panel Physician for the first 90 days of your work injury or illness if you expect WSSD to pay for the medical treatment you receive. Refer to the enclosed ***Workers' Compensation Guidelines for Injured Worker***.
5. 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.
6. **Give** your supervisor the ***Supervisor's Workers' Compensation Incident Investigation Report*** form to complete and forward to Human Resources Department.

Please call Human Resources (Eileen) at 610-892-3470 extension 1406 if you have questions regarding you work-related injury.

All work related injury claims are coordinated through:

CM Regent Insurance Company – WC Division
300 Sterling Parkway, Suite 100
Mechanicsburg, PA 17050

To be completed by the Employee.

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 ☐ ☐		Marital Status: M ☐ F ☐ Dep.:	
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
(866) 402-6600 Fax: (866) 402-6601 www.CMRegent.com

To be completed by the Employee

RIGHTS AND DUTIES FORM - SIDE 1

NOTIFICATION TO EMPLOYEES OF THEIR RIGHTS AND DUTIES UNDER SECTION 306 (f.1)(1)(i) OF THE PA. WORKERS' COMPENSATION ACT

The Pennsylvania Workers' Compensation Act requires that employees be given written notification of their rights and duties under Sec. 306 (f.1)(1)(i) of the Act if a list of designated health care providers is established by the employer. Below are your rights and duties under Sec. 306 (f.1)(1)(i) and an acknowledgment signature line. This acknowledgment, signed by you, is to be returned to your employer.

A brief summary: You have the right to seek emergency medical treatment from any provider; for post-emergency and other injuries, you must obtain treatment for work-related injuries and illnesses from a designated health care provider for 90 days. The penalty for not using a designated health care provider is that your employer is not liable for the medical bills incurred.

As an employee of the Commonwealth working at a location where a list of designated health care providers has been established and posted, you have:

- The duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
- The right to seek 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.
- 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.
- The right, during this 90-day period, to switch from one designated health care provider to another designated provider.
- The right to seek treatment from a provider if you are referred to that provider by a designated provider.
- The right to an additional opinion from a provider of your choice when invasive surgery is prescribed by the designated provider.
- The right to seek treatment or medical consultation from a non designated provider during the 90-day period, but the services shall be **at your expense** for the applicable 90 days.
- The right to seek treatment from any health care provider after the 90-day period has ended.
- The duty to **notify your employer of treatment by a non designated provider (after the 90 day period) within 5 days of the first visit to that provider.** The employer may not be required to pay for treatment rendered by a non designated provider prior to receiving this notification.

I acknowledge that I have been informed of my rights and duties
under Sec. 306 (f.1)(1)(i) and that I understand them
to the extent that they are explained above.

Print Name _____ Employee Signature _____ Date _____

See reverse for a complete text of Section 306 (f.1)(1)(i)
If you have any questions, ask your human resources office representative or call
The Bureau of Workers' Compensation at 1-800-482-2383

RIGHTS AND DUTIES FORM - SIDE 2

PENNSYLVANIA WORKERS' COMPENSATION ACT
SECTION 306 (f.1)(1)(i)

The employer shall provide payment in accordance with this section for reasonable surgical and medical services, services rendered by physicians or other health care providers, including an additional opinion when invasive surgery may be necessary, medicines and supplies, as and when needed. Provided an employer establishes a list of at least six designated health care providers, no more than four of whom may be a coordinated care organization and no fewer than three of whom shall be physicians, the employee shall be required to visit one of the physicians or other health care providers so designated and shall continue to visit the same or another designated physician or health care provider for a period of ninety (90) days from the date of the first visit: provided, however, that the employer shall not include on the list a physician or other health care provider who is employed, owned or controlled by the employer or the employer's insurer unless employment, ownership or control is disclosed on the list. Should invasive surgery for an employee be prescribed by a physician or other health care provider so designated by the employer, the employee shall be permitted to receive an additional opinion from any health care provider of the employee's own choice. If the additional opinion differs from the opinion provided by the physician or health care provider so designated by the employer, the employee shall determine which course of treatment to follow: provided, that the second opinion provides a specific and detailed course of treatment. If the employee chooses to follow the procedures designated in the second opinion, such procedures shall be performed by one of the physicians or other health care providers so designated by the employer for a period of ninety (90) days from the date of the visit to the physician or other health care provider of the employee's own choice. Should the employee not comply with the foregoing, the employer will be relieved from liability for the payment for the services rendered during such applicable period. It shall be the duty of the employer to provide a clearly written notification of the employee's rights and duties under this section to the employee. The employer shall further ensure that the employee has been informed and that he understands these rights and duties. This duty shall be evidenced only by the employee's written acknowledgment of having been informed and having understood his rights and duties. Any failure of the employer to provide and evidence such notification shall relieve the employee from any notification duty owed, notwithstanding any provision of this act to the contrary, and the employer shall remain liable for all rendered treatment. Subsequent treatment may be provided by any health care provider of the employee's own choice. Any employee who, next following termination of the applicable period, is provided treatment from a nondesignated health care provider shall notify the employer within five (5) days of the first visit to said health care provider. Failure to so notify the employer will relieve the employer from liability for the payment for the services rendered prior to appropriate notice if such services are determined pursuant to paragraph (6) to have been unreasonable or unnecessary.

To be completed by the Employee

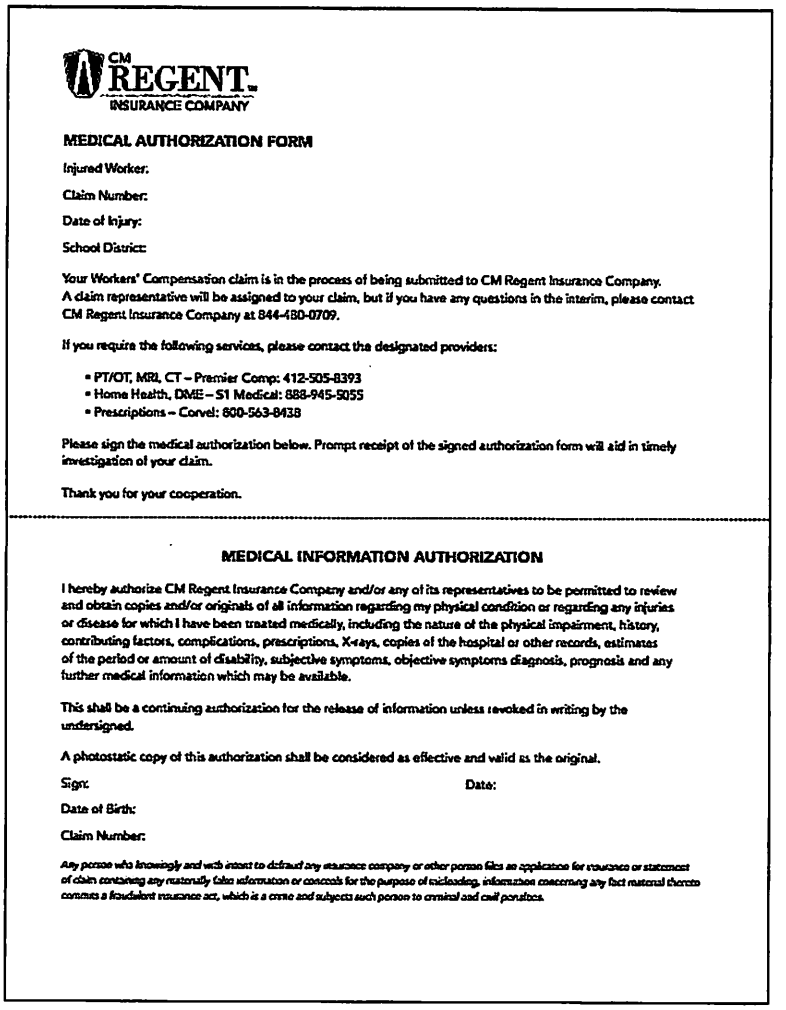
CM REGENT™
INSURANCE COMPANY

Employee Medical Authorization Form

What It Is: Form signed by Injured Worker (IW) at time of injury to secure medical records and be able to speak to the treating medical providers.

Importance: Allows for more timely request for medical records (pre- and post-injury) thus allowing a more thorough investigation of the claim.

How Form is to Be Used: Upon notification of an injury, provide form to the IW for review and signature. Fax form to CM Regent® at 866-402-6601 upon receipt of online claim referral (which will provide claim number).



CM REGENT.
INSURANCE COMPANY

MEDICAL AUTHORIZATION FORM

Injured Worker:

Claim Number:

Date of Injury:

School District:

Your Workers' Compensation claim is in the process of being submitted to CM Regent Insurance Company. A claim representative will be assigned to your claim, but if you have any questions in the interim, please contact CM Regent Insurance Company at 844-480-0709.

If you require the following services, please contact the designated providers:

- PT/OT, MRI, CT – Premier Comp: 412-505-8393
- Home Health, DME – S1 Medical: 888-945-5055
- Prescriptions – Corvel: 800-563-8438

Please sign the medical authorization below. Prompt receipt of the signed authorization form will aid in timely investigation of your claim.

Thank you for your cooperation.

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize CM Regent Insurance Company and/or any of its representatives to be permitted to review and obtain copies and/or originals of all information regarding my physical condition or regarding any injuries or disease for which I have been treated medically, including the nature of the physical impairment, history, contributing factors, complications, prescriptions, X-rays, copies of the hospital or other records, estimates of the period or amount of disability, subjective symptoms, objective symptoms diagnosis, prognosis and any further medical information which may be available.

This shall be a continuing authorization for the release of information unless revoked in writing by the undersigned.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Sign: Date:

Date of Birth:

Claim Number:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full-sized form on next page

CM REGENT™
INSURANCE COMPANY

MEDICAL AUTHORIZATION FORM

Injured Worker: _____

Claim Number: _____

Date of Injury: _____

School District: _____

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Sign: _____ Date: _____

Date of Birth: _____

Claim Number: _____

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WALLINGFORD SWARTHMORE
SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT

SUPERVISOR'S WORKERS' COMPENSATION INCIDENT INVESTIGATION REPORT

(Must be **completed by the supervisor**, not the employee, and returned to Eileen Seichepine in Human Resources)

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 and investigate the conditions by which the claim was reported.

PLEASE PRINT

Employee name _____ Date of injury _____

Location of injury: _____

1. What is the Employee's description of the occurrence?

_____

_____

_____

_____

2. Describe the resulting injuries:

_____

_____

3. What type of footwear; describe type of footwear and sole worn at the time of injury.

_____

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. What was the last day worked? _____
9. Was there a third party involved causing the accident? __ yes __ no
   If yes; Student, Employee, Other
10. Witness Name(s): _____

_____

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

_____

_____

_____

Supervisor signature _____ Date _____

02-01-2020

CM REGENT INSURANCE COMPANY

Panel of Physicians

Wallingford Swarthmore School District - Wallingford

Your Workers' Compensation Insurance Carrier is:

CM Regent Insurance

300 Sterling Pkwy, Suite 100 Mechanicsburg, PA 17050

Phone: 1-717-590-8008

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR WORK INJURY.

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 ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. 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.
5. 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 physician's 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.
6. 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.

FOR ASSISTANCE IN SCHEDULING APPOINTMENTS, PLEASE CALL PREMIER COMP TOLL FREE 24 HOURS/7 DAYS A WEEK AT 1-888-594-4001

Name	Address	Phone	Area of Specialty
Concentra Medical Centers (Multiple Locations)	1017 4th Avenue, Suite 200 Essington, PA 19029 Location #: 610-521-6880	1-888-594-4001	Occupational Medicine
Vybe Urgent Care (Multiple Locations)	213 Morton Avenue Folsom, PA 19033 Location #: 610-285-9500	1-888-594-4001	Urgent Care/Occupational Medicine
Crozer Centers for Occupational Health	1553 Chester Pike, Suite 204 Crum Lynne, PA 19022 Location #: 610-595-6811	1-888-594-4001	Occupational Health
AFC Urgent Care (Multiple Locations)	5024 Pennell Road Aston, PA 19014 Location #: 610-550-8144	1-888-594-4001	Urgent Care
Patient First (Multiple Locations)	417 Baltimore Pike Springfield, PA 19064 Location #: 484-470-2600	1-888-594-4001	Urgent Care/Occupational Medicine
Rothman Orthopaedic Institute (Multiple Locations)	1118 West Baltimore Pike, Suite 302 Media, PA 19063 Location #: 267-339-3776	1-888-594-4001	Orthopedics
Premier Orthopedic & Sports Medicine Associates (Multiple Locations)	200 East State Street, Suite 108 Media, PA 19063 Location #: 610-876-0347	1-888-594-4001	Orthopedics
Premier Orthopedics / Liberty Division	1 Bartol Avenue, Suite 100 Ridley Park, PA 19078 Location #: 610-521-8970	1-888-594-4001	Orthopedics
Delaware Valley Surgical Associates	30 Lawrence Road, Suite 700 Broomall, PA 19008 Location #: 610-853-1662	1-888-594-4001	General Surgery
Global Neurosciences Institute at Crozer (Multiple Locations)	175 East Chester Pike Ridley Park, PA 19078 Location #: 610-595-6272	1-888-594-4001	Neurology
Starer, Rizzo & Ruffini Ophthalmology	1510 Chester Pike Eddystone, PA 19022 Location #: 610-521-2111	1-888-594-4001	Ophthalmology
Hometown Wellness & Chiropractic	120 East State Street, Suite 100 Media, PA 19063 Location #: 610-566-9575	1-888-594-4001	Chiropractic
Springfield Hospital	190 West Sproul Road Springfield, PA 19064 Location #: 610-328-8700	1-888-594-4001	Emergency Medicine

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Corvel	For Prescriptions, Please Call	1-800-563-8438	Pharmacy
S1 Medical	Call Toll Free for Closest Location	1-888-945-5055	DME, Home Health, & Dentist

Panel Date: 1/27/2023

To be completed by the Physician

CM REGENT™
INSURANCE COMPANY

Patient Name: _____
Date of Birth: _____
Claim Number: _____

PHYSICAL CAPABILITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8-hour workday, patient can stand/walk:
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during the day) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   ☐ No restrictions
2. In an 8-hour workday, patient can sit:
   (Hours at one time) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (Total hours during the day) ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   ☐ No restrictions
3. In an 8-hour workday, patient can drive car/truck:
   (Minutes at one time) ☐ 10-30 ☐ 30-60
   (Hours at one time) ☐ 1-3
   ☐ No restrictions
4. Patient can lift/carry:

Maximum lbs:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80
Frequently:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

   ☐ No restrictions or above
5. Patient can use hands for repetitive:
   A. Simple Grasping ☐ Yes ☐ No
   B. Pushing and Pulling ☐ Yes ☐ No
   C. Fine Manipulation ☐ Yes ☐ No
   ☐ No restrictions
6. Patient can use feet for repetitive movement as in operating foot controls:
   ☐ Yes ☐ No
   ☐ No restrictions
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

   ☐ No restrictions
8. Is patient restricted by environment factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No Restriction
   ☐ Yes—Please Explain _____
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No Restriction
   ☐ Yes—Please Explain _____
10. When will patient be released to return to work:
    Light duty _____ Full duty _____
11. Will patient be required to use any assistive devices or braces?
    ☐ No Restriction
    ☐ Yes—Please Explain
12. Additional comments: _____
    _____
13. Date of next office appointment: _____

_____ _____ _____
Physician's Name/Group Physician's Signature Date

PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 866-402-6601 and provide a copy to the patient.

To be Completed by Physician

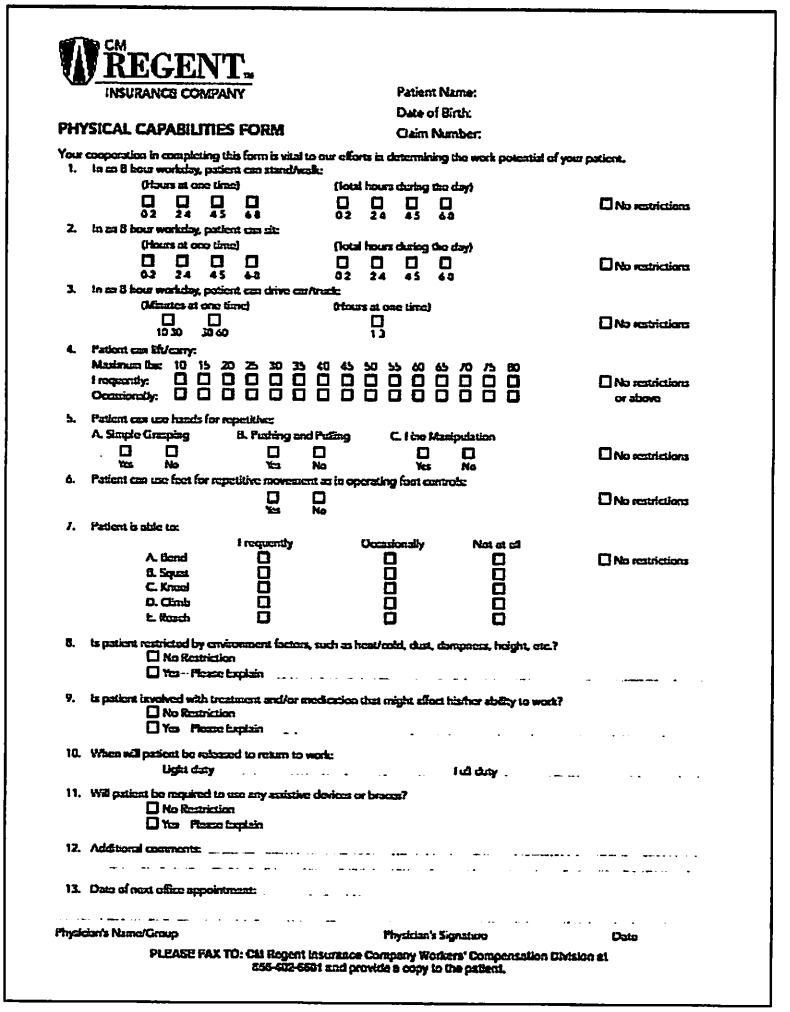
CM REGENT™
INSURANCE COMPANY

Treating Provider Physical Capabilities Form

What It Is: Form completed by treating/panel physician (at time of injury and ongoing throughout course of treatment of work injury) with a detailed breakout of the injured worker's (IW) current physical abilities to attempt to allow IW to remain in the workforce.

Importance: Provides immediate update to employer and claim representative as to what pre-injury work duties the IW is able to perform and/or provides assistance to employer in developing transitional duty (if applicable).

How Form Is to Be Used: Upon notification of an injury that requires treatment, provide form to the IW and to the panel doctor for completion by treating/panel physician.



CM REGENT™
INSURANCE COMPANY

Patient Name:
Date of Birth:
Claim Number:

PHYSICAL CAPABILITIES FORM

Your cooperation in completing this form is vital to our efforts in determining the work potential of your patient.

1. In an 8 hour workday, patient can stand/walk:
   (Hours at one time): ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (total hours during the day): ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   ☐ No restrictions
2. In an 8 hour workday, patient can sit:
   (Hours at one time): ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   (total hours during the day): ☐ 0-2 ☐ 2-4 ☐ 4-5 ☐ 6-8
   ☐ No restrictions
3. In an 8 hour workday, patient can drive car/truck:
   (Minutes at one time): ☐ 10-30 ☐ 30-60
   (Hours at one time): ☐ 1-3
   ☐ No restrictions
4. Patient can lift/carry:
   Maximum lbs: 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80
   Frequently: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   Occasionally: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
   ☐ No restrictions or above
5. Patient can use hands for repetitive:
   A. Simple Grasping: ☐ Yes ☐ No
   B. Pushing and Pulling: ☐ Yes ☐ No
   C. Fine Manipulation: ☐ Yes ☐ No
   ☐ No restrictions
6. Patient can use feet for repetitive movement as in operating foot controls:
   ☐ Yes ☐ No
   ☐ No restrictions
7. Patient is able to:

	Frequently	Occasionally	Not at all
A. Bend	☐	☐	☐
B. Squat	☐	☐	☐
C. Kneel	☐	☐	☐
D. Climb	☐	☐	☐
E. Reach	☐	☐	☐

   ☐ No restrictions
8. Is patient restricted by environment factors, such as heat/cold, dust, dampness, height, etc.?
   ☐ No Restriction
   ☐ Yes – Please Explain .....
9. Is patient involved with treatment and/or medication that might affect his/her ability to work?
   ☐ No Restriction
   ☐ Yes Please Explain .....
10. When will patient be released to return to work:
    Light duty ..... Full duty .....
11. Will patient be required to use any assistive devices or braces?
    ☐ No Restriction
    ☐ Yes Please Explain
12. Additional comments: .....
13. Date of next office appointment: .....

Physician's Name/Group ..... Physician's Signature ..... Date .....

PLEASE FAX TO: CM Regent Insurance Company Workers' Compensation Division at 855-612-6581 and provide a copy to the patient.

Full-sized form on next page

If needed, to be completed by Physician

CM REGENT™
INSURANCE COMPANY
Workers' Compensation Division

TRANSITIONAL RTW DUTY FORM

School District Name: WALLINGFORD-SWARTHMORE SCHOOL DISTRICT

School District Address: 200 S. Providence Rd, WALLINGFORD, PA 19086

School District Contact: Eileen Seichepine - Human Resources - Benefits

School District Phone Number: 610-892-3470 x 1406 Fax Number: 610-892-3424
eseichepine@wssd.org

Employer: Provide this form to the attending physician

*****REMINDER TO MEDICAL PROVIDER*****

EMPLOYEES ARE OUR MOST VALUABLE ASSET!

WE OFFER MODIFIED DUTY!

It is the policy of WSSD to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding our modified duty program, please contact us.

Thank you!

(To be completed by the physician)

_____ Yes, employee may return to work on regular duty (no restrictions).

_____ Yes, employee may return to work on modified duty (see restrictions).

_____ No, employee may NOT return to work (see restrictions).

Physician's Signature: _____

Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:

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

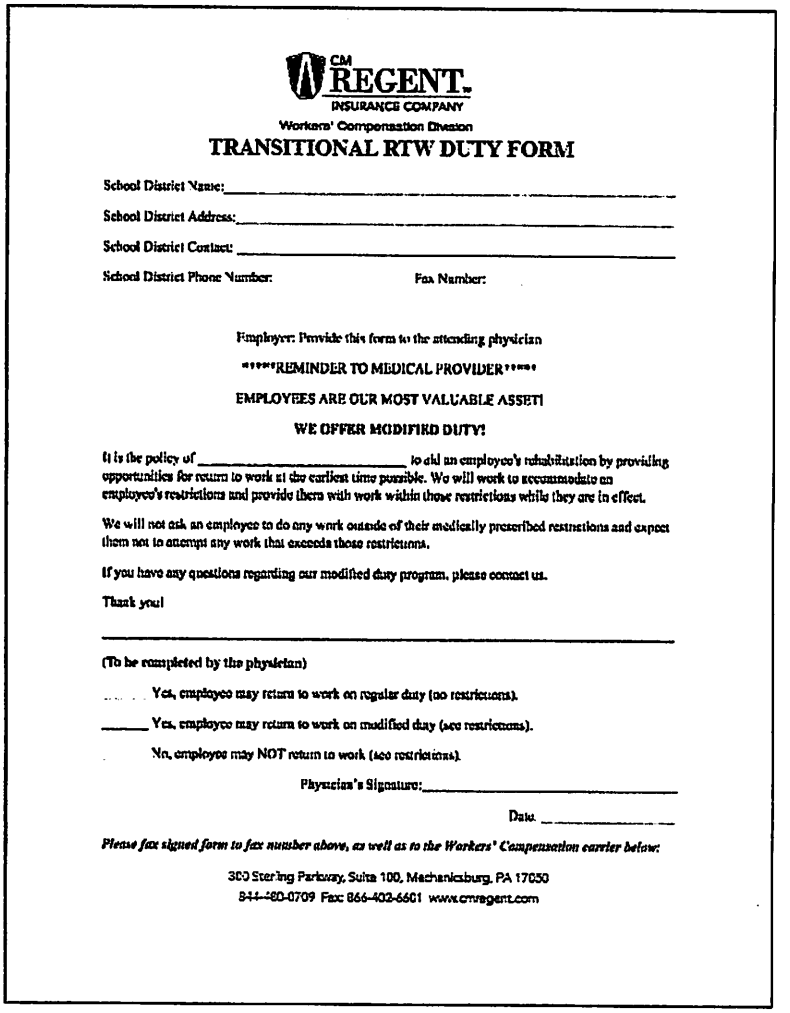
CM REGENT™
INSURANCE COMPANY

Employer Transitional RTW Duty Form

What It Is: The document used to alert everyone involved in the injured worker's care that the school has transitional/modified duty work.

Importance: Faxed to the medical provider along with the Physical Capabilities Form. Can be used anytime during the life of the claim.

How Form is Used: The completed form is used to assist the school and CM Regent® WC Department to work together for a timely return to work for the employee.



CM REGENT.
INSURANCE COMPANY
Workers' Compensation Division

TRANSITIONAL RTW DUTY FORM

School District Name:_____

School District Address:_____

School District Contact: _____

School District Phone Number: Fax Number:

Employer: Provide this form to the attending physician

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It is the policy of _____ to aid an employee's rehabilitation by providing opportunities for return to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding our modified duty program, please contact us.

Thank you!

_____

(To be completed by the physician)

_____ Yes, employee may return to work on regular duty (no restrictions).

_____ Yes, employee may return to work on modified duty (see restrictions).

No, employee may NOT return to work (see restrictions).

Physician's Signature:_____

Date: _____

Please fax signed form to fax number above, as well as to the Workers' Compensation carrier below:

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

Full-sized form on next page

CM REGENT™
INSURANCE COMPANY

Injured Worker's First Fill Prescription Form

Claimant Name: _____

Date of Injury: _____ SSN: _____

Notice to Injured Worker and Pharmacy

This temporary First Fill card is only valid if used within 30 days of the reported date of injury. Temporary eligibility through this program allows for a one time fill of prescription medications. For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.**

Injured Worker Instructions

On your first Pharmacy visit, please give this notice to any pharmacy listed on this insert to expedite the processing of your approved Workers' Compensation prescriptions, based on the parameters established by **CM Regent Insurance Company.** With the CorVel pharmacy program, you do not need to complete any paperwork or claim forms. Simply present this CorVel First Fill Prescription Form to the pharmacy. You should not incur any costs or co-pays at the pharmacy and you will be allowed up to a 14 day supply of medications.

Pharmacy Instructions

For assistance processing claims please contact the CorVel Pharmacy Department at **(800) 563-8438.** Please use the BIN, PCN, and RxGroup number below to process an online/electronic claim to CorVel:

CORVEL CVS CAREMARK

BIN:	**004336**
PCN:	**ADV**
RxGroup:	**RXFFWC7277479**
Member ID:	**See below to generate ID**

To Generate Member ID: The Injured Worker's 9 digit Social Security Number plus 8 digit Date of Injury will be used as their 17 digit **Member Identification number** when processing their First Fill Prescription:
XXXXXXXXXMMDDYYYY

Below is a sample listing of some of the over 72,000 Participating Pharmacies in the CorVel Network. Please call **(800)563-8438** for a participating pharmacy near you.

CostCo Pharmacy	H.E.B. Pharmacies	Meijer Pharmacy	Smith's Food & Drug Centers
CVS	Hy-Vee Pharmacy	Publix Pharmacy	Target Pharmacy
Dominick's Finer Foods	Ingles Pharmacy	Raley's Drug Center	Von's Pharmacy
Drug Mart	Kroger Pharmacy	Rite Aid Pharmacy	Wal-Mart Pharmacy
Fred's Pharmacy	Longs Drug Store	Safeway Pharmacy	Walgreens Pharmacy
Giant Eagle Pharmacy	Marc's Pharmacy	Sav-On Drug Store	Wegman Pharmacy
Giant Food Stores, LLC	Medicine Shoppe	Shoprite Supermarkets	Winn Dixie Pharmacy

CORVEL

U.S. Food and Drug Administration
Drug Safety Communication

Safety Announcement
The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. We are requiring changes to the labels of all opioid drugs to warn about these risks.

More specifically, the labels will warn about the following:

- Opioids can interact with antidepressants and migraine medicines to cause a serious central nervous system reaction called serotonin syndrome, in which high levels of the chemical serotonin build up in the brain and cause toxicity.
- Taking opioids may lead to a rare, but serious condition in which the adrenal glands do not produce adequate amounts of the hormone cortisol. Cortisol helps the body respond to stress.
- Long-term use of opioids may be associated with decreased sex hormone levels and symptoms such as reduced interest in sex, impotence, or infertility.

Opioids are a class of powerful narcotic pain medicines that are used to treat moderate to severe pain that may not respond well to other pain medicines. They can help manage pain when other treatments and medicines are not able to provide enough pain relief, but they also have serious risks including misuse and abuse, addiction, overdose, and death.

Facts about Opioids

- Opioids are powerful prescription medicines that can help manage pain when other treatments and medicines are not able to provide enough pain relief. However, opioids also carry serious risks, including of misuse and abuse, addiction, overdose, and death.
- Prescription opioids are divided into two main categories – immediate-release (IR) products, usually intended for use every 4 to 6 hours; and extended release/long acting (ER/LA) products, intended to be taken once or twice a day, depending on the individual product and patient.
- Certain opioids, such as methadone and buprenorphine, can also be prescribed as a form of treatment for opioid addiction.
- Opioids are available in many different formulations, including tablets, capsules, lozenges, sublingual tablets, transdermal patches, nasal sprays, and injections.
- Common side effects of opioids include drowsiness, dizziness, nausea, vomiting, constipation, physical dependence, and slowed or difficult breathing.
- The risk of opioid addiction, abuse or misuse is increased in patients with a personal or family history of substance abuse, or mental illness.
- It is important to lock up opioids and to dispose of them properly to keep them from falling into the wrong hands.

CM REGENT™
INSURANCE COMPANY

What To Do If You Are Injured At Work

As soon as practical, report the incident to your supervisor, Human Resources or your employer's Workers' Compensation coordinator so they can report it to our office, even if you don't think you need medical treatment.

- Make sure your employer has your up-to-date contact information, including phone numbers, home address and personal email.

Your employer will file your claim electronically with CM Regent®, who will assign a claim representative to work with you going forward.

- If you require medical treatment, your employer will give you a copy of your injury report that will include your confirmation/claim number. To avoid delays, take the injury report with you to your initial doctor's appointment.
- When seeking medical attention for a work-related injury occurring after hours, tell the medical provider that yours is a Workers' Compensation injury. Remember to report the incident to your employer the next business day.

Your employer should give you a copy of your Provider Panel.

- A Provider Panel is a list of medical providers you may see for the first 90 days following a work-related injury. You must sign a form acknowledging you received the Provider Panel information.

PLEASE NOTE: If immediate emergency care is needed, go to the nearest emergency room for the initial visit. Follow-up visits should then be scheduled with a medical provider on the Provider Panel.

Write down questions you may have for your medical provider and take them with you on your first visit.

- Communicate any concerns about your treatment to your medical provider and to your CM Regent Claim Representative.

The following services should be scheduled through the providers listed during the first 90 days of a claim.

- PT/OT, MRI, CT – Premier Comp: 412-505-8393
- Home Health, DME – S1 Medical: 888-945-5055
- Prescriptions – Corvel: 800-563-8438

Continued...

- You can expect contact from your claim representative between 8 a.m. and 4:30 p.m. to discuss your injury and if applicable, a treatment strategy.
- Watch your mail for paperwork you will need to fill out immediately and return to our office or give to your medical provider. A self-addressed stamped envelope will be included for the materials that are to be sent back to CM Regent.
- You will receive a pharmacy card once your claim has been accepted and Workers' Compensation benefits are approved. Use this card to purchase all medications prescribed by your medical provider.
- Call your claim representative after every doctor appointment to relay the most current medical and return-to-work information.

CM Regent wants to help get you back to your pre-accident condition as quickly as possible. If you have any questions or concerns, please do not hesitate to call our office at 1-844-480-0709.