The Seubert Safe Workplace

The Seubert Safe Workplace is a program initiated to help our commercial insurance clients their control worker compensation costs and improve employee health and well-being.

A Seubert Safe Workplace consists of four components:

1. A Physicians Panel
2. A Safety Committee
3. An Accident Investigation Procedure
4. A Return to Work Program

* some information provided by Eastern Alliance Insurance Group and Royal and Sun Alliance.

Component 1: Physicians Panel

Pennsylvania state workers' compensation law provides that an employer may post a panel of physicians that employees injured on the job must treat with for a period of 90 days, beginning with the first date of treatment.

Setting up a physicians panel has many benefits:

- **Ensures prompt, appropriate treatment** for work-related injuries by physicians specially trained in occupational medicine.

- **Prevents "doctor shopping"** by injured workers to seek a medical opinion that will provide or extend their disability.

- **Reduces medical cost and potentially eliminates costly litigation** by provides control over the treatment.

- **Decreases or eliminates disability** through transitional return to work utilizing medical providers who are familiar with the insurance carrier's protocol.

- **Fosters open lines of communication** between employer, medical provider and insurance carrier regarding treatment and return to work.

- **Clearly identifies any work restrictions** of an injured worker that may prohibit full duty via a physical capacity form, after evaluating employee for transitional duty.

To set up a physicians panel, contact your Seubert representative.

Once a panel is in place, have each employee sign an **Employee Acknowledgement Form**. A copy of the form follows this page.

EMPLOYEE'S ACKNOWLEDGEMENT
UNDER SECTION 306(F.1)(1)(i)

I, _____, understand and agree that my employer has posted a list of at least six health care providers, at least three (3) of which are physicians and no more than four (4) of which are coordinated organizations (CCO).

I further agree that my employer has provided the name, address, telephone number and area of medical specialty of each designated provider on the list.

I also acknowledge that I have been presented with this written notice setting forth my rights and responsibilities under Section 306(f.1)(1)(i) of the Pennsylvania Workers' Compensation Act. My rights and responsibilities include the following:

1. I have the duty to obtain treatment for work-related injuries and illnesses from one or more of the designated health care providers for **ninety (90) days from the date of first visit to a designated provider;**

2. As long as treatment is obtained from a designated provider during the ninety (90) day period, all reasonable medical supplies and treatment related to the injury will be paid by my employer;

3. I have the right to switch from one designated health care provider on the list to another during the ninety (90) day period and my employer must pay for this treatment;

4. If I am referred by a designated provider to a non-designated provider, my employer shall provide for the treatment rendered by the referral provider;

5. I have the right to seek emergency medical treatment from any provider but I understand that subsequent non-emergency treatment must be rendered by a designated provider for the remainder of the ninety (90) day period;

6. I have the right during the ninety (90) day period to seek medical treatment from a non-designated provider, but I understand that my employer is not responsible to pay for these services;

7. After the expiration of the ninety (90) day period, I have the right to seek treatment from any health care provider and my employer must pay for such treatment if it is reasonable and necessary;

8. If I treat with a non-designated health care provider after the expiration of the ninety (90) day period, I understand that I must provide my employer with notice within five (5) days of my first treatment with the non-designated provider. If I fail to do so my employer may not be responsible to pay for treatment rendered by the non-designated provider prior to notification; and

9. If a designated provider recommends invasive surgery, I understand that I may obtain a second opinion from a non-panel provider. Should I elect to follow the treatment plan recommended by the non-panel provider, I understand that I must obtain that treatment from a panel provider for ninety (90) days from the date of the appointment with the non-panel provider.

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

_____	_____
DATE	EMPLOYEE'S SIGNATURE
_____	_____
DATE	WITNESS

Component 2: Safety Committees

Safety committees help make employees aware of the need for safety along with giving the insured a 5% credit on their workers' compensation policy. The state of Pennsylvania has developed safety committee guidelines and requirements, as well as a Technical Assistance Manual. You can access all the information on the PA Department of Labor and Industry website. The address for the appropriate page is:

www.dli.state.pa.us/landi/cwp/view.asp?a=138&q=58600

Component 3: Accident Investigation Procedure

Accident investigation can pinpoint problem areas and faulty equipment. This can help companies correct problems and help prevent repeat occurrences. It can also help identify faulty claims.

There are eight steps to investigating an accident or injury:

1. Interview the employee regarding the injury. Details are important and the employee may provide more information to you than to the insurance company. Have the employee fill out and sign an **Injured Employee's Report** form. A copy of the form follows this section.

2. Secure any faulty equipment or photograph any unsafe condition on the premises. This may be important evidence in a third-party subrogation action.

3. Examine the accident scene and compare the condition to the employee's version (ex: water of floor, weight of object being lifted, etc.)

4. Interview witness using the **Witness Incident Report form**. A copy of the form follows this section. Remember, what a witness *doesn't* see is sometimes as important as what they do see.

5. Take corrective action.

6. Place a copy of the investigation in the employee's personnel file.

7. Provide your findings to your claims team.

8. Use the accident as a learning tool. Discuss it at safety meetings and focus on prevention.

INJURED EMPLOYEE'S REPORT

Please complete the entire form

Name:	SS#:
Address: (Street)	Phone #:
(city) *(zip)* *(county)*	Date of Birth:
Marital Status:	# of children under 18:
Job Title:	Date of hire:

Accident Information

Date of accident: / /	Time of accident: a.m./p.m.
Date returned to work: / /	Start time: a.m./p.m.
Exact location of accident:	Address of accident:

Describe in detail the events leading up to the accident and how it happened: (attach additional pages if necessary)

To whom did you report the accident to and when?

List the part(s) of your body which were injured. Be specific.

Did you seek medical treatment? If yes, where were you treated and by whom?

Did defective equipment, material, furnishings, co-workers, or another river contribute to the accident? If yes, describe the how.

List the witness(s) to the accident:

Please indicate if you have ever injured this part of your body before. Yes No (Please circle)

If so, when and where?

Employee's Signature

Date

Component 4: Return to Work Program

You need to provide return to work opportunities for employees who have been injured on the job, because:

- It's a critical component of **claims management**.

- It provides the needed **sense of contribution and interaction** with peers to legitimately injured employees.

- It helps **prevent abuse** of the system for suspect injuries or by employees who exaggerate the extent of their injuries.

- It **controls the cost of lost wages**, which is substantially higher than medical costs associated with claims.

- It helps **control the costs of a claim** and ultimately the cost of your workers' compensation insurance.

An effective return to work program can demonstrate a company's commitment to the health and well-being of its employees. At the same time, it can improve a company's productivity and profitability.

To implement the program, you'll utilize the following forms, which you can find at the end of this section:

- **Employer's Job Evaluation form**
- **Physician's Evaluation form**
- **Modified Duty Form**

WITNESS INCIDENT REPORT

To be completed and signed by witness only

This report will be submitted to the Worker's

Compensation Insurer as part of claim

Full Name: _____ **Telephone Number:** _____

Date of Incident: _____ **Time of Incident:** _____

Who the accident involved:

_____

In your own words describe what you witnessed with as much detail as possible:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Names of other witnesses:

_____

_____

_____

_____ _____

WITNESS SIGNATURE **DATE AND TIME OF REPORT**

Keys to a Successful Return to Work Program

- **Establish a program before you need it.** Make sure that management, supervisors and employees understand their roles and responsibilities.

- **Communicate the program's purpose and goals to supervisors.** Some may be hesitant to provide a position to an employee who is less than "100%." Emphasize to them the rehabilitative and productivity value of the program and its role in controlling workers' compensation costs.

- **When possible, modify the employee's own position to meet their physical limitations.** Design modified positions to be productive and useful. To accommodate physical limitations, you may place the employee on another shift or in a different department. An employee may worry that "modified duty" means "menial tasks." However, keep in mind that any work within the employee's physical capabilities is better than no work at all.

EMPLOYER'S JOB EVALUATION

Employer's Name _____ **Workplace Address**_____

Name of Evaluator_____ _____

Date_____ _____

Job Title_____ **Industry Type**_____

Description of Job_____

Description of Workplace_____

Environmental Conditions (Temp. extremes, air quality, noise, heights, etc.)

_____

Equipment Utilized_____

Hours Worked Daily:

Lunch Break _____ **Minutes / Additional Breaks** _____

PHYSICAL REQUIREMENTS OVER THE COURSE OF A WORKDAY:

LIFT	REGULARLY (67% - 100%)	FREQUENTLY (34% - 66%)	OCCASSIONALLY (1% - 33%)	NOT AT ALL
0 - 10 lbs.				
11 - 20 lbs.				
21 - 50 lbs.				
51 - 100 lbs.				
101+ lbs.				

CARRY	REGULARLY (67% - 100%)	FREQUENTLY (34% - 66%)	OCCASSIONALLY (1% - 33%)	NOT AT ALL
0 - 10 lbs.				
11 - 20 lbs.				
21 - 50 lbs.				
51 - 100 lbs.				
101+ lbs.				

DURING THE WORKDAY, THE WORKER WILL:

MOTION	5-8 HOURS	3-5 HOURS	1-3 HOURS	NOT AT ALL
Stand/Walk				
Sit				
Bend				
Squat				
Climb				
Kneel				
Push/Pull				
Reach				
Crawl				
Overhead Reach				
Grasp (Hands)				

OTHER REQUIREMENTS

Driving_____

_____

Use of Hands_____

_____

Operate Foot Controls_____

_____

Comments_____

_____

_____

_____

_____

THE ABOVE MENTIONED POSITION IS AVAILABLE

Permanently_____ Temporarily_____ Length of Time_____

Signature_____

Title _____

Date _____

PHYSICIAN'S EVALUATION

Name_____ Soc. Security #_____ Date of Injury _____

Address_____

Date of Birth_____ Occupation _____ Date of First Visit_____

Employer Name & Address_____

History of Injury:_____

Diagnosis:_____

Recommendations for Work:

_____ Regular Work _____ Modified Work ____ No Work

Full Time / Part Time

_____ _____ **Sedentary Work**: Lifting 10 pounds maximum and occasionally lifting and/or carrying small articles

_____ _____ **Light Work:** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds.

_____ _____ **Medium Work:** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects up to 25 pounds.

_____ _____ **Heavy Work:** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects up to 50 pounds.

_____ _____ **Very Heavy Work:** Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.

Position Limitations:

	Hrs/Day
Standing	
Reaching above shoulders	
Repetitive wrist motion	
Squatting	
Kneeling	

	Hrs/Day
Sitting	
Reaching below waist	
Exposure to vibrating tools	
Climbing	

Patient Disposition:

_____ Off work from _____

_____ Return to work no modification, _____

_____ Return to work with above modification _____

_____ No work until _____ or next office visit _____

_____ Referral to _____

_____ Treatment plan_____

Comments_____

_____

_____

Physician's Name _____Physician's Signature _____

Note to Injured Worker: 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 ______________________ *(company's name)* to aid an employee's rehabilitation by providing opportunities for returning 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 __________________ *(company's name)* modified duty program, please contact _____________________ *(contact person)* at ______________________ (phone number).

Thank you!

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(To be completed by Physician)

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

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

____
Physician's Signature

____
Date
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