ReliableHomeHealth

Workers' Compensation Information

To All Employees:

The workers' compensation law provides wage loss & 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 if self-injured, 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 & at its sites of employment in a prominent & easily accessible place. It is also required to be posted in any areas used for 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:

Bureau of Workers' Compensation
1171 South Cameron St, Room 103
Harrisburg, PA 17104-2501
Telephone # within PA: 1-800-482-2383
Telephone # outside this Commonwealth: 717-772-4447
TTY: 1-800-362-4228 (for hearing & speech impaired only)
www.state.pa.us, PA keyword: workers' comp

For a complete list of panel physicians, please contact your employer. Please call 1-800-633-1197 with any additional questions.

I, _____ employee of Reliable Home Health, certify that I have been provided with, read, and understood the information set forth above consistent with the requirements of the Pennsylvania Workers' Compensation Act.

Date: _____

Employee's Acknowledgement Form Under Section 306(f)(1)(i) Of The Pennsylvania Workers' Compensation Act

I recognize & agree that my employer has provided a list of at least 6 designated health care providers, no more than 2 of whom are coordinated care organizations & no fewer than 3 of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for 90 days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment of services rendered during this 90-day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within 5 days of my first visit to each & every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

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

_____

Employee's Printed Name Employees Signature Date

Witness' Signature: _____ Date: _____