RESOLUTION NO. 94- 4

WORKERS' COMPENSATION POLICY AND PROCEDURE FOR MEMBERS OF VOLUNTEER FIRE COMPANIES AND MEMBERS OF VOLUNTEER AMBULANCE CORPS UNDER SECTION 601(a) OF THE WORKMEN'S COMPENSATION ACT

BE IT HEREBY RESOLVED, that the Supervisors of Penn Forest Township, Carbon County, Pennsylvania, adopt the following Workers' Compensation Policy and Procedure for Members of Volunteer Fire Companies and Members of Volunteer Ambulance Corps Under Section 601(a) of the Workmen's Compensation Act.

I. **PURPOSE**.

Pursuant to Section 601(a) of the Workmen's Compensation Act, under certain circumstances, members of volunteer fire companies and members of volunteer ambulance corps (hereinafter collectively referred to as "members"), are considered "employees" of the township. The purpose of this policy is to provide an efficient and effective procedure for administratively handling injuries which occur to members, and to determine whether or not such members are "employees" under Section 601(a) of the Workmen's Compensation Act. Investigation of workers' compensation claims involves teamwork between the claims representative, township, member, and treating physician. This relationship must be maintained for the purpose of expeditiously determining compensability and the best course of action for restoring

the injured worker to gainful employment. By using the policy and procedure outlined below, the township/member can also be assured of fair, prompt administration and disposition of a worker's compensation claim.

II. REPORT OF INJURY/INVESTIGATION OF CLAIM.

Any member injured while performing any duty or service of or for a volunteer fire company or volunteer ambulance corps, whether or not intending at that time to file a workers' compensation claim, must notify the Township Secretary in writing as soon as reasonably possible after the occurrence of the accident. At the time of reporting the injury, the employee shall complete and sign a "Member's Report of Accident." This report shall include the date, time, location and description of injury, as well as the name(s) of any witnesses and shall also include the specific body area(s) injured. Because the Township Secretary must also complete and sign a Statement of Injury, the member shall cooperate with the Secretary in obtaining additional information which may be required.

Soon after the report of an injury has been made, the member will be contacted by the Township's insurance adjuster. At this time, the member will be given the opportunity to offer his version of the accident as well as a history of the medical treatment rendered for the injury. The member should be prepared to offer a detailed description of the accident and identify any third party involvement in the injury. The member should also be prepared to discuss any prior claims filed by the member whether they are occupationally related or not.

III. INFORMATION FROM HEALTH CARE PROVIDER.

In the event a member receives treatment from a health care provider and requires a leave of absence from work, the following provisions shall apply:

After initial medical consultation, a medical target date for the member to return to his work either at modified or full duty status shall be established. Once a target date has been established, the member shall advise the Township Secretary of such date in writing as soon as possible.

The Township may request and the member shall provide medical reports from the member's treating physician at reasonable intervals and the Township has the right to refuse payment of medical services until those reports are provided. Every member shall sign a Release for the collection of such medical reports and records by the Township. Such release will avoid any delays in the investigation of the claim and will facilitate the workers' compensation process. The medical reports should contain at a minimum:

A. Patient information including the physician's description of the injury as related to him by the member;

B. A statement regarding the injury itself, including a notation as to whether the complaints are subjective or objective in nature;

C. The treatment plan devised by the physician and whether the member has cooperated with such

treatment including physical therapy, prescribed medications, etc.;

D. A statement of the member's disability, including his functional capacities and the duration and extent of the member's limitations;

E. Amount of total medical expenses incurred to date;

F. Signature of physician and date of signature.

Additionally, the Township may maintain contact with the member as needed to determine the status of his health and medical treatment.

IV. **TERMINATION OF CLAIM**.

Upon a physician's determination of full recovery, a member shall sign an Agreement to Stop Compensation Payments which will have the effect of terminating benefits. In the event a member returns to work at wages equal to those of his pre-injury job, but has not recovered from his work injury, a Supplemental Agreement suspending benefits shall be executed.

V. **DESIGNATED PHYSICIANS**.

Penn Forest Township reserves the right to designate a panel of six (6) health care providers pursuant to Pennsylvania's Workers' Compensation Law from which a member must seek initial treatment for a period of at least thirty (30) days. At this time, the Township has not yet designated a panel of health care providers Accordingly, an injured member may visit a health care provider of his own choosing.

VI. **INDEPENDENT MEDICAL EXAMINATION.**

The township may request that a member visit a physician, designated by the township, to obtain an independent medical examination. Independent medical examinations shall be considered when:

1. The member's treating physician refuses to establish a target date for resuming full and modified employment;
2. The member fails to meet the treating physician's target date;
3. The disability appears to be excessive given the nature of the injury;
4. The member refuses to return to full or modified employment after being released to return to work;
5. The medical treatment appears to be excessive, unreasonable, or unnecessary.
6. Under the circumstances it is reasonable for the Township to request an independent medical examination.

VII. **DISCIPLINARY ACTION.**

The Township shall not discriminate against any member filing a meritorious Workers' Compensation claim or any member presenting evidence regarding the claim of an injured worker. In the event any member is found, after reasonable investigation, to have filed a falsified claim or assisted in the filing of a falsified claim,

such member may be subject to disciplinary action.

This Policy is hereby adopted on the 1st day of August, 1994, to help ensure the accurate, detailed, and timely reporting of an occupational injury, and the subsequent administration thereof.

PENN FOREST TOWNSHIP BOARD
OF SUPERVISORS

ACKNOWLEDGMENT OF RECEIPT OF POLICY

I hereby acknowledge receipt of the Workers' Compensation Policy and Procedure for Members of Volunteer Fire Companies and Members of Volunteer Ambulance Corps.

DATE:_____ _____

RELEASE

TO WHOM IT MAY CONCERN:

I hereby consent and request that Penn Forest Township or any of its representatives be permitted to examine and obtain copies of all hospital and medical records of every sort and kind, interview all doctors and other attendants and all employers and former employers regarding all matters relating to examination, diagnosis, care and treatment of myself, earnings and loss of earnings.

I am willing that a photostat of this authorization be accepted with the same authority as the original.

Date_____ Signed_____

Address_____

_____

MEMBER OF VOLUNTEER FIRE COMPANY OR MEMBER OF VOLUNTEER AMBULANCE CORPS. REPORT OF ACCIDENT

DATE OF ACCIDENT:_____ TIME OF ACCIDENT:_____ SUPERVISOR:_____

IN YOUR OWN WORDS DESCRIBE YOUR ACCIDENT. TELL HOW AND WHERE THE ACCIDENT HAPPENED AND INCLUDE THE SPECIFIC BODY AREAS INJURED. LIST ANYONE WHO WITNESSED THE ACCIDENT.

MEMBER NAME:_____ DATE:_____
(PRINT)

SIGNATURE:_____

SECRETARY'S STATEMENT OF INJURY

INSTRUCTIONS

1. Member Name: _____

2. Member's Home Address: _____

3. Member's Home Telephone Number: _____

4. Member's Date of Birth: _____ 5. Social Security No.: _____

6. Date Membership began: _____

7. Name of Immediate Supervisor: _____

8. Is Member Represented By A Union (at member's place of work)? _____

9. Physical Description of Member:

   a. Height _____ b. Weight _____

   c. Hair _____ d. Eye Color _____

10. Brief Description of the Member's Duties:

_____

_____

11. Is Modified Work Available (at member's place of work)? _____

12. History Of All Prior Workers' Compensation/Unemployment/Group Claims:

_____

13. Were Any Post Offer, Pre-Placement Physicals Conducted? _____

14. Were Periodic Physicals Performed? _____

15. Has There Been A Pattern Of Disciplinary Action Or Attendance Problems Within The Last Two Years Of The Loss?_____

16. Where Did The Accident Occur?_____

17. Owner Of The Premises On Which The Accident Occurred? _____

_____

18. Did The Injuries Occur From A Motor Vehicle Accident? _____

19. Names Of All Witnesses: _____

20. Details Of The Accident: _____

_____

_____

_____

_____

_____

21. Whether There Was Any Police Or Emergency/Rescue Squad Called To The Scene?

_____

22. Were Any Mechanical Defects Involved In The Injury? _____

23. Any Other Unusual Circumstances Surrounding The Claim? _____

_____

_____

24. What Action Has Been Taken To Prevent Any Reoccurrence? _____

_____

_____

_____

a. Date Action Taken _____ b. Action Taken By _____

25. Was There A Delay In The Reporting Of This Accident? If So, Explain.

_____

_____

26. Was The Member Aware Of The Township's Workers' Compensation Policy And Procedure?

_____

_____ DATE:_____TOWNSHIP SECRETARY

CHAIRMAN OF THE BOARD OF SUPERVISORS REVIEW OF INVESTIGATION

I HAVE REVIEWED THIS INVESTIGATION AND CONCUR WITH THE FINDINGS/RESULTS

SIGNATURE:_____ DATE:_____