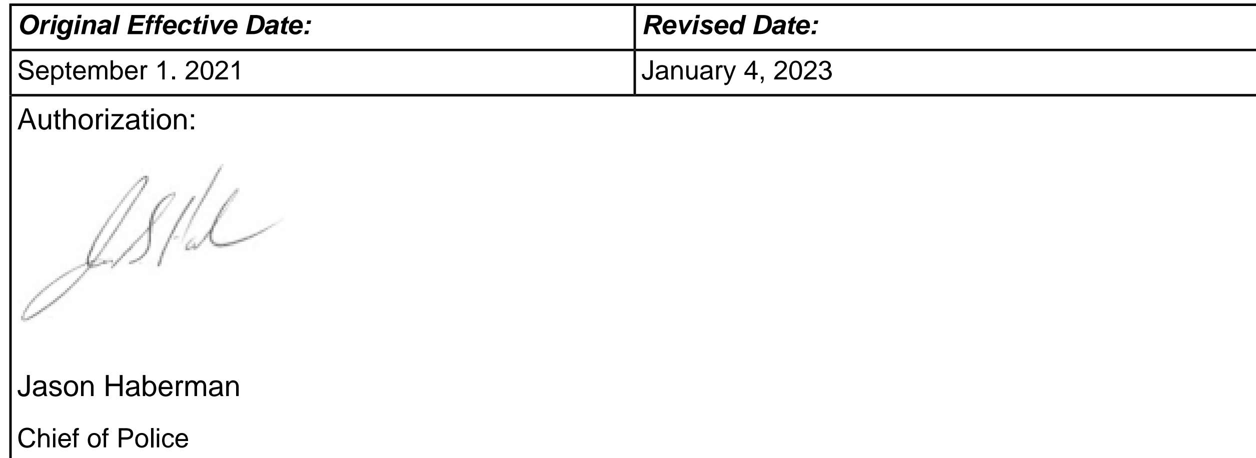
Work-Related Injury and Occupational Disease Reporting

1022.1 POLICY HEADER

Original Effective Date:	***Revised Date:***
September 1. 2021	January 4, 2023
Authorization:  Jason Haberman Chief of Police	

1022.2 PURPOSE AND SCOPE

The purpose of this policy is to provide guidance regarding timely reporting of work-related injuries, mental health issues and occupational diseases.

1022.2.1 DEFINITIONS

Definitions related to this policy include:

Work-related injury or occupational disease - Any injury arising in the course of the member's employment. The term includes any occupational disease (as defined in 77 P.S. § 27.1) that occurs within the preceding 300 weeks of the member's employment with the Mt. Lebanon Police Department. The term work-related injury does not include an injury caused by the act of a third person intending to injure the member because of personal reasons or reasons unrelated to the member's employment with the Mt. Lebanon Police Department or an injury sustained while the member was operating a vehicle while not otherwise in the course of employment at the time of the injury (77 P.S. § 411).

1022.3 POLICY

The Mt. Lebanon Police Department will address work-related injuries, mental health issues and occupational diseases appropriately, and will comply with applicable state workers' compensation requirements (77 P.S. § 1 et seq.).

1022.4 RESPONSIBILITIES

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1022.4.1 MEMBER RESPONSIBILITIES
Any member sustaining any occupational disease or work-related injury shall report such event as soon as practicable, but within 24 hours to a supervisor, and shall seek medical care when appropriate.

1022.4.2 SUPERVISOR RESPONSIBILITIES
A supervisor learning of any work-related injury or occupational disease should ensure the member receives medical care as appropriate.

Supervisors shall ensure that required documents (Occupational Injury Report and Worker's Compensation Injury Report) regarding workers' compensation are completed and forwarded promptly. Any related Municipality wide injury or disease-reporting protocol shall also be followed.

Supervisors shall determine whether the Major Incident Notification and Illness and Injury Prevention policies apply and take additional action as required.

1022.4.3 DEPUTY CHIEF OF POLICE RESPONSIBILITIES
The Deputy Chief of Police who receives a report of an occupational disease or work-related injury should review the report for accuracy and determine what additional action should be taken. The report shall then be forwarded to the Chief of Police, the Municipality's risk management entity and the Support Services Deputy Chief of Police to ensure any required reporting is made as required in the disease and injury prevention plan identified in the Illness and Injury Prevention Policy.

1022.4.4 CHIEF OF POLICE RESPONSIBILITIES
The Chief of Police or the authorized designee shall review and forward copies of the report to the Human Resources Director. Copies of the report and related documents retained by the Department shall be filed in the member's confidential medical file.

1022.5 OTHER DISEASE OR INJURY
Diseases and injuries caused or occurring on-duty that do not qualify for workers' compensation reporting shall be documented on the designated report of injury form, which shall be signed by a supervisor. A copy of the completed form shall be forwarded to the appropriate Deputy Chief of Police through the chain of command and a copy sent to the Support Services Deputy Chief of Police.

Unless the injury is extremely minor, this report shall be signed by the affected member, indicating that he/she desired no medical attention at the time of the report. By signing, the member does not preclude his/her ability to later seek medical attention.

1022.6 SETTLEMENT OFFERS
When a member sustains an occupational disease or work-related injury that is caused by another person and is subsequently contacted by that person, his/her agent, insurance company or attorney and offered a settlement, the member shall take no action other than to submit a written report of this contact to his/her supervisor as soon as possible.

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1022.6.1 NO SETTLEMENT WITHOUT PRIOR APPROVAL

No less than 10 days prior to accepting and finalizing the settlement of any third-party claim arising out of or related to an occupational disease or work-related injury, the member shall provide the Chief of Police with written notice of the proposed terms of such settlement. In no case shall the member accept a settlement without first providing written notice to the Chief of Police. The purpose of such notice is to permit the Municipality to determine whether the offered settlement will affect any claim the Municipality may have regarding payment for damage to equipment or reimbursement for wages against the person who caused the disease or injury, and to protect the Municipality's right of subrogation, while ensuring that the member's right to receive compensation is not affected.

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Attachments

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WC - Injury Report Form - Fillable.pdf

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INSTRUCTIONS FOR COMPLETING FORM LIBC-344

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

This form is in a "pdf" fillable format which must be opened in Adobe Reader, version 8.0 or later. Once you have opened the form you can enter and edit the data; save and print copies; and return the completed form to MRM Workers' Compensation Pooled Trust as an email attachment to report an injury.

YOU WILL NEED TO KEEP A BLANK COPY OF THIS FORM AS A MASTER COPY.

Each time you need to file a report, retrieve the blank MASTER COPY, complete the form and SAVE THE COMPLETED FILE USING A DIFFERENT NAME. The new file name should use the following format:

LASTNAME_YYYY-MM-DD

using the claimant's last name and the Year-Month-Day on which the report is being made.

Please send the newly-named file to MRM as an email attachment to: WC-Claims@mrmtrust.com

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800-482-2383
TTY (TOLL FREE) 800-362-4228

EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR DISEASE

EMPLOYEE SOCIAL SECURITY NUMBER

DATE OF INJURY

MONTH DAY YEAR

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

STREET ADDRESS

CITY STATE ZIP CODE

COUNTY PHONE NUMBER

EMPLOYEE:
MALE MARRIED
FEMALE SINGLE

NUMBER OF DEPENDENTS

DATE OF BIRTH
MONTH DAY YEAR

OCCUPATION OR JOB TITLE

NCCI CLASS CODE (IF KNOWN)

EMPLOYMENT STATUS
FT = Full-time
PT = Part-time
SL = Seasonal
VO = Volunteer
ZZ = Other

EMPLOYER

STREET ADDRESS

CITY STATE ZIP CODE

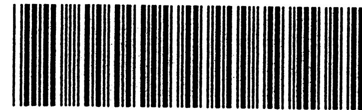
SIC CODE EMPLOYER FEIN PHONE NUMBER

COUNTY NAICS CODE

FULL PAY FOR DAY OF INJURY?
YES
NO

TIME EMPLOYEE BEGAN WORK
AM
PM

TIME OF OCCURRENCE
AM
PM



LAST DAY WORKED
MONTH DAY YEAR

DATE DISABILITY BEGAN
MONTH DAY YEAR

DATE EMPLOYER NOTIFIED
MONTH DAY YEAR

DATE RETURNED TO WORK
MONTH DAY YEAR

DATE OF HIRE
MONTH DAY YEAR

CONTACT FIRST NAME

CONTACT PHONE NUMBER

CONTACT LAST NAME

NOTICE: Report should be clearly completed, (preferably typed) and original mailed to the Bureau at the address in the upper left corner and a copy to employee and insurer.

TYPE OF INJURY CODE

PART OF BODY AFFECTED CODE

CAUSE OF INJURY CODE (ENTER CODES, IF KNOWN)

TYPE OF INJURY OR ILLNESS

PARTS OF BODY AFFECTED

CAUSE OF INJURY

DID INJURY OR ILLNESS OCCUR ON EMPLOYER'S PREMISES?
YES
NO

IF OUT OF STATE, SPECIFY STATE OF INJURY

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?
YES
NO

WERE SAFEGUARDS OR SAFETY EQUIPMENT USED?
YES
NO

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES DIRECTLY RESPONSIBLE

IF FATAL, GIVE DATE OF DEATH

MONTH DAY YEAR

PHYSICIAN/HEALTH CARE PROVIDER

FIRST NAME: LAST NAME:
STREET
CITY STATE ZIP

HOSPITAL NAME:
STREET
CITY STATE ZIP

INITIAL TREATMENT:
- NO MEDICAL TREATMENT
- MINOR BY EMPLOYEE
- CLINIC / HOSPITAL
- PANEL PHYSICIAN
- EMPLOYEE PHYSICAN
- EMERGENCY CARE
- HOSPITALIZED MORE THAN 24 HOURS

POLICY PERIOD FROM:

MONTH DAY YEAR

POLICY PERIOD TO:

MONTH DAY YEAR

POLICY/SELF INSURED NUMBER:

WITNESS FIRST NAME

WITNESS PHONE NUMBER

WITNESS LAST NAME

PERSON COMPLETING THIS FORM:
NAME:
TITLE:
PHONE:

INSURANCE CARRIER OR THIRD PARTY ADMINISTRATOR (IF SELF-INSURED)
NAME: MRM WC Pooled Trust
STREET 2591 Wexford-Bayne Road, Ste. 301
CITY Sewickley STATE PA ZIP 15143
BUREAU CODE: 5500 FEIN: 25-1687566

DATE PREPARED

MONTH DAY YEAR

344 1197-2

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

Occupational Injury Report Fillable Form.pdf

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PERSONNEL FORM

OCCUPATIONAL INJURY REPORT

Employee Profile

Employee Name: ______________________________

Address: ______________________________

Date of Birth: ______________________

Telephone: ______________________

Hire Date: ______________________

Marital Status: ______________________

# of children under 18: ______________________

Employment Information

Status	Assignment	Employment Group	
Full Time	Administration	Managerial	Fire
Part Time	Public Works	Support	Police
Temporary	Parks & Rec	Administrative	Intern/Student
Probationary	Police	Craft & Labor	Part Time
	Fire	Other: ______________	

Notes

Accident Information

Date of Accident	Time of Accident
Nature of injury and location on body	
Detailed description of accident (include exact location and work employee was doing when injured; names of persons witnessing accident; map or diagram may be used to describe accident)	
Treating physician or hospital:	
Address:	

If medical treatment received, please sign attached medical authorization.

Is employee expected to miss work as a result of injury?	Submitted by:	Reg Employment (Vol. Fire only)	Investigated by: