



# Workers Compensation Claim Reporting Worksheet and Guide

We will produce and submit the necessary state forms and filings.



**DO NOT DELAY IN REPORTING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.**

**PLEASE EMAIL YOUR COMPLETED FORM TO [first.report@travelers.com](mailto:first.report@travelers.com) OR CALL 1.800.238.6225.**

<b>ACCOUNT / ACCIDENT INFORMATION</b>			
PREPARER'S PHONE NUMBER	PREPARER'S TITLE	PREPARER'S NAME	EMPLOYMENT STATE
SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP) <input type="checkbox"/> SAME	
DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED			
PARENT COMPANY / INSURED'S NAME			
LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS	
DATE OF INJURY	TIME OF INJURY		
ACCIDENT DESCRIPTION			
<b>EMPLOYEE INFORMATION</b>			
	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	PRIMARY LANGUAGE
	EMPLOYEE'S MAILING ADDRESS		
EMPLOYEE'S PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS	

**EMPLOYEE JOB INFORMATION**

EMPLOYMENT STATUS CODE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> OTHER	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
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OCCUPATION WHEN INJURED

EMPLOYEE'S WORK SCHEDULE

REGULAR WORK HOURS	HOURS/DAY	DAYS/WEEK
_____	_____	_____

EMPLOYEE'S WAGE INFORMATION:

\$ \_\_\_\_\_ HOUR      OR \$ \_\_\_\_\_ / ANNUAL      OR \_\_\_\_\_ / WEEKLY      OVERTIME: \$ \_\_\_\_\_      ADD'L BENEFITS: \$ \_\_\_\_\_

DATE OF HIRE OR LENGTH OF EMPLOYMENT

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	SUPERVISOR'S EMAIL ADDRESS:	BEST HOURS TO CONTACT
_____	_____	_____	_____

**ACCIDENT INFORMATION**

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK OR ARE THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THE EMPLOYEE BACK AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, DATE RETURNED TO WORK?  IS THERE AN ANTICIPATED RETURN TO WORK DATE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, ANTICIPATED RETURN DATE?
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RETURN TO WORK STATUS <input type="checkbox"/> LIGHT <input type="checkbox"/> MODIFIED <input type="checkbox"/> REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH <input type="checkbox"/> YES <input type="checkbox"/> NO
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DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT ARE YOU QUESTIONING? <input type="checkbox"/> INJURY WORK RELATED <input type="checkbox"/> EXTENT OF INJURY <input type="checkbox"/> OTHER
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**WITNESS INFORMATION**

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

NAME (FIRST, MI, LAST)	PHONE NUMBER
_____	_____

ADDRESS

<b>INJURY INFORMATION</b>	
CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)	
PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)	
NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)	
PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE) <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>TREATMENT (“X” ALL THAT APPLY)</b>	
<input type="checkbox"/> UNKNOWN <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> FIRST AID/MINOR ON SITE TREATMENT <input type="checkbox"/> DOCTOR’S OFFICE/WALK-IN CLINIC <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> HOSPITAL/CLINIC – ADMITTED >24 HOURS	
DESCRIPTION OF TREATMENT AND DATE OF 1st TREATMENT	
NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY	
PHYSICIAN NAME	
<b>INSURED CONTACT INFORMATION</b>	
CONTACT NAME	PHONE NUMBER
EMAIL ADDRESS	BEST TIME TO CONTACT AND WHERE TO CONTACT
ADDITIONAL NOTES/COMMENTS OR CUSTOMER SPECIFIC INFORMATION	



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This material is for informational purposes only. All statements herein are subject to the provisions, exclusions and conditions of the applicable policy. For an actual description of all coverages, terms and conditions, refer to the insurance policy. Coverages are subject to individual insureds meeting our underwriting qualifications and to state availability.

CE-10347 New 12-17

# GETTYSBURG COLLEGE

300 N Washington Street

Gettysburg, PA 17325

January 2025

## PENNSYLVANIA WORK-RELATED INJURIES

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 prostheses, including training in their use.

In order to ensure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the designated health care providers listed below:

### ***Occupational Medicine Clinic***

Gettysburg Wellspan Occ Health  
455 S. Washington St, Suite 12  
Gettysburg, PA 17325  
Phone: 717-339-2880

### ***Occupational***

Hanover Wellspan Occ Health  
1150 Carlisle St., Suite 21  
Hanover, PA 17332  
Phone: 717-851-7070

### ***Family Practice***

Gettysburg Family Practice  
524 S. Washington Street  
Gettysburg, PA 17325  
Phone: 717-334-2183

### ***Urgent Care Clinic***

Wellspan Urgent Care  
455 S. Washington St.  
Gettysburg, PA 17325.

### ***Occupational Medicine Clinic***

Concentra Medical Center  
1124 Harrisburg Pike  
Carlisle, PA 17013  
Phone: 717-267-2273

### ***Orthopedic Surgery***

OSS Health Gettysburg  
20 Expedition Trail, Suite 110-B  
Gettysburg, PA 18325  
Phone: 717-339-0700

### ***Urgent Care Clinic***

MedExpress Urgent Care  
1048 Lincoln Way E, Suite 101  
Chambersburg, PA 17201  
Phone: 717-267-2273

### ***Orthopedic Surgery***

OSS Health Hanover  
470 Eisenhower Drive  
Hanover, PA 17332  
Phone: 717-633-0031

### ***Orthopedic Surgery***

Wellspan Orthopedics  
18 Deatrick Drive  
Gettysburg, PA 17325  
Phone: 717-339-2500

### ***Ophthalmology***

Gettysburg Ophthal Assoc.  
455 S Washington Street, Suite 24  
Gettysburg, PA 17325  
Phone : 717-334-9159

### ***Chiropractor***

Adams County Chiroipractic  
445 Old Harrisburg Road  
Gettysburg, PA 17325  
Phone: 717-337-1190

### ***General Surgery***

Gettysburg Surgical Assoc  
450 W Washington St, Suite C  
Gettysburg, PA 17325  
Phone: 717-339-3110

### ***Chiropractor***

Gettysburg Chiropractic Center  
1080A Chambersburg Road  
Gettysburg, PA 17325  
Phone : 717-334-5566

### ***Wellspan Orthopedics Hanover***

207 Blooming Grove Road  
Hanover, PA 17331  
Phone : 717-812-7559

### ***Diagnostic Testing***

Adams Diagnostic Imaging  
20 Expedition Trail, Suite 103  
Gettysburg, PA 17325  
Phone: 717-337-5991

### ***Diagnostic Testing***

***One Call Care Management***  
***Call for scheduling***  
***Phone: 800-872-2875***

### ***Physical Therapy***

Gentle OT/Hand Clinic  
1010 Eichelberger Street, Suite 5  
Hanover, PA 17331  
Phone: 717-656-0440

### ***Physical Therapy***

Wellspan Rehabilitation  
16-C Deatrick Drive  
Gettysburg, PA 17325  
Phone: 717-339-2540

### ***Physical Therapy***

Adams County Physical Therapy  
110 W. Eisenhower Drive, Suite E  
Hanover, PA 17331  
Phone: 717-646-8104

### ***Physical Therapy***

Wellspan Rehabilitation  
40V Twin Drive, Suite 101  
Gettysburg, PA 17325  
Phone: 717-339-2620

### ***Pharmacy-Any Major Pharmacy***

Healthsystems-BIN# 012874  
Phone: 877-528-9497  
If assistance is needed, please take  
Injured Employee Prescription Fill Form  
to your pharmacy

\*\*(NOTE: If any of the health care providers listed above are employer, owned or controlled by the employer or the employer's carrier, it will be so designated by an asterisk next to the health care provider's name.)

You must continue to visit one of these health care providers listed above, if you need treatment, for ninety (90) days from the date of your first visit.

After this ninety (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider. You **MUST** notify your employer of this action within five (5) days of your visit to the health care providers of your choice.

Your bills will be considered IF: your health care provider files written reports on a form prescribed by the Department (these reports must be filed within ten (10) days of commencing treatment and at least once a month thereafter, as long as treatment continues).

If one of the health care providers listed above refers you to another health care provider, your employer or its insured will pay the bill for these services provided they are reasonable and necessary.

If you are faced with a medical emergency, you may secure assistance from a hospital or health care provider of your choice.