Three steps to follow if you are injured while at work:

1. Report your injury to your supervisor.
2. Call to speak to a Registered Nurse.
3. Provide employer TCC account number to the nurse.

TUNKHANNOCK AREA SCHOOL DISTRICT

TCC Number: 101165

TeleCompCare®

866-323-4227

AccidentFund.com/TeleCompCare

UnitedHeartland.com/TeleCompCare

CompWestInsurance.com/TeleCompCare

3CU.com/TeleCompCare

TeleCompCare® Workflow

Workplace Injury

Need to speak with a triage nurse?

Call TeleCompCare Nurse Triage

866-323-4227

For Spanish, press #9

Employee must provide

Employer Name: TUNKHANNOCK AREA SCHOOL DISTRICT

TCC Account Number: 101165

Employer Address:

Report claim only (No nurse intervention)

Nurse Triage with Employee

Self-Care

- Triage nurse will provide self-care instructions to employee
- Employee will receive text message with care instructions
- Employee returns to normal working duties
- Nurse will offer to follow up with employee within 24 hours to confirm symptoms improved

Clinic Referral

- After speaking with nurse, the employee is transferred to an agent who assists with locating a preferred provider
- In provider panel states, employee will be instructed to follow up with their supervisor

Telemedicine

To use this option, the employee must have a personal email address and device with audio/video

- After speaking with a nurse, employee is transferred to an agent who can assist with telemed application
- Physician reviews triage notes while employee creates personal login for appt.
- Any DME, imaging or PT will be scheduled with employee
- Any prescription orders are sent directly to pharmacy
- Return to work note emailed to employer

Options:

- Report claim via brand website portal
- Call TCC triage line, press option #2 and provide employer policy number

First notice of loss entered into claim system by staff member

*If applicable, employer directs employee to complete post-accident drug test

- Triage report sent to employer via email
- Triage data electronically received into claim system to create new claim

AFGroup.com

AF Group

AccidentFund
Insurance Company of America
Part of the AF Group

Employee Accident Investigation Report

This form is to be completed by the injured employee and the supervisor in charge at the time of the accident.

FACILITY

NAME	CITY	STATE	LOCATION #

EMPLOYEE

NAME	SEX	D.O.B.	HEIGHT	WEIGHT
		/ /		

SOCIAL SECURITY #	HIRE DATE	FULL TIME	PART TIME	SHIFT: DAY	EVENING	NIGHT
— —	/ /	☐	☐	☐	☐	☐

DEPARTMENT	ADDRESS

JOB CLASSIFICATION	CITY, STATE	HOME PHONE #
		( )

DESCRIPTION OF ACCIDENT

ACCIDENT DATE	ACCIDENT TIME	ACCIDENT LOCATION
/ /	: a.m. ☐ p.m. ☐	

Please describe the accident, including what employee was doing when it occurred.

Name object or substance that directly attributed to the accident.

What caused the accident? How could it have been prevented?

Describe the injury.

BODY PART

☐ 1. Abdomen	☐ 13. Forearm(s)	☐ 25. Ribs
☐ 2. Ankle(s)	☐ 14. Groin	☐ 26. Shoulder(s)
☐ 3. Back	☐ 15. Hand(s)	☐ 27. Spine
☐ 4. Buttock(s)	☐ 16. Head	☐ 28. Stomach
☐ 5. Calf(s)	☐ 17. Hip(s)	☐ 29. Teeth
☐ 6. Chest	☐ 18. Jaw	☐ 30. Thigh(s)
☐ 7. Ear(s)	☐ 19. Knee(s)	☐ 31. Throat
☐ 8. Elbow(s)	☐ 20. Leg(s)	☐ 32. Thumb(s)
☐ 9. Eye(s)	☐ 21. Lungs	☐ 33. Toe
☐ 10. Face	☐ 22. Mouth	☐ 34. Upper Arm(s)
☐ 11. Finger(s)	☐ 23. Neck	☐ 35. Whole Body
☐ 12. Foot	☐ 24. Nose	☐ 36. Wrist(s)

TYPE OF CONDITION

☐ 1. Abrasion	☐ 13. Grinding Wound	☐ 25. Repetitive Motion Disorder
☐ 2. Amputation	☐ 14. Hearing Loss	☐ 26. Scratch
☐ 3. Avulsion	☐ 15. Heart Attach	☐ 27. Sliver
☐ 4. Blister	☐ 16. Heat (cramps, stroke)	☐ 28. Splinter
☐ 5. Burn	☐ 17. Hernia	☐ 29. Sprain/Strain
☐ 6. Contusion	☐ 18. Infection	☐ 30. Slip/Fall
☐ 7. Death	☐ 19. Insect Bite	☐ 31. Other _____
☐ 8. Dermatitis	☐ 20. Irritation (dust)	
☐ 9. Foreign Object	☐ 21. Irritation (vapor)	
☐ 10. Fracture	☐ 22. Laceration	
☐ 11. Frostbite	☐ 23. Pulmonary Condition	
☐ 12. Ganglion	☐ 24. Puncture Wound	

Corrective actions taken to prevent reoccurrence.

Treatment

- ☐ *First Aid*
- ☐ *Panel of Physicians*
- ☐ *Emergency Room*
- ☐ *Personal Physician/Clinic*
- ☐ *Refused Treatment*
- ☐ *Other (name)*

Lost Time?	*Number of Days:*	*Modified/Restricted Duty*	NUMBER OF DAYS
☐ *Yes* ☐ *No*		☐ *Yes* ☐ *No*	

Did employee accept medical treatment?	*Was employee hospitalized?*	*Did employee return to work the same day?*
☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*	☐ *Yes* ☐ *No*

Report Date	**Employee Signature**	**Supervisor Signature**
/ /		

NOTICE TO EMPLOYEES

Your employer has provided for the payment of
Benefits under the Workers' Compensation Act of this State

IN CASE OF WORK-RELATED INJURY

- 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 immediately advise your supervisor of your injury, and be treated by one of the licensed physicians or practitioners of the healing arts listed below:

DESIGNATED PHYSICIANS
(including address, telephone number, and area of medical specialty)

Clinics
Guthrie Clinic Tunkhannock
5950 Sr 6
Ste 101
Tunkhannock, PA 18657
(800) 244-4886

Clinics
Express Urgent Care
449 Scranton Carbondale Hwy
Scranton, PA 18508
(570) 344-6000

Clinics
Medicus Urgent Care
1208 Oneill Hwy
Dunmore, PA 18512
(570) 207-2612

Clinics
Disa Global Solutions
1000 Meade St
Ste 108 (Appointment Req)
Dunmore, PA 18512
(570) 209-7160

Clinics
LVPG Occupational Medicine - Pittston
1120 Oak St
Pittston, PA 18640
(570) 299-3384

Orthopedics
LVPG Orthopedics & Sports Med
John T Rich
1120 Oak St
Pittston, PA 18640
(570) 299-3384

Orthopedics
Guthrie Tunkhannock Orthopedics
Joshua Wilbur-PA
5950 SR 6
Tunkhannock PA 18657
570-836-4294

General Surgery
LVPG General Surgery
James J Roche
5 Morgan Hwy
Ste 7
Scranton, PA 18508
(570) 344-1231

Neurology
Professional Neurological Associates
Vithalbhai Dhaduk
1444 E Lackawanna Ave
Olyphant, PA 18447
(570) 963-8803

- You must continue to visit one of these persons listed above, if you need treatment, for ninety (90) day from the date of your first visit. If you do not, your employer may not be required to pay these services.
- After this ninety (90) day period, if you still need treatment and your employer had provided a list as set forth above, you may choose to go to another licensed physician or practitioner of the healing arts for treatment. You must notify your employer of this action within five (5) days of your visit to the person of your choice, or your employer may not be required to pay for these services.
- Your bills will be paid for IF: your licensed physician or practitioner of the healing arts files reports as required. (These reports must be filed within ten (10) days after your first visit and at least once a month for as long as treatment continues.)
- In the event a posted panel physician recommends invasive surgery, you may seek a second opinion with a physician of your choice. If you choose to undergo the invasive surgery, you must use a posted physician for the treatment.
- If no list is provided as above, you may go to a licensed physician of practitioner of the healing arts of your choice.
- If one of the persons listed above refers you to another licensed specialist, your employer or his insurer will pay the bill for these services.
- If you are faced with a medical emergency, you may secure assistance from a hospital or physician or practitioner of the healing arts of your choice.

REMEMBER, IT IS IMPORTANT TO TELL YOUR EMPLOYER ABOUT YOUR INJURY