Acknowledgement/Receipt of Policies

Workers' Compensation
I hereby acknowledge that I have been informed of and understand my rights and duties under the Workers' Compensation Act. I have received a copy of the "Workers' Compensation and the Injured Worker" brochure, the "Workers' Compensation Policy," and a list of the approved medical facilities panel.
Initial _____

New Health Insurance Marketplace Coverage
I hereby acknowledge that I have received a copy of the "New Health Insurance Marketplace Coverage, Part A and part B".
Initial _____

Internet Use Policy
I hereby acknowledge that I have received a copy of the "Internet Use Policy." I have read and understand all the provisions specified in this policy.
Initial _____

Safety Policy
I hereby acknowledge that I have received a copy of the "Safety Policy." I have read and understand all the provisions specified in this policy.
Initial _____

Anti-Harassment Policy
I hereby acknowledge that I have received a copy of the "Anti-Harassment Policy." I have read and understand all the provisions specified in this policy.
Initial _____

Violence in the Workplace Policy
I hereby acknowledge that I have received a copy of the "Violence in the Workplace Policy." I have read and understand all the provisions specified in this policy.
Initial _____

Payroll Periods & Service Policy
I hereby acknowledge that I have received a copy of the "Payroll Periods & Service Policy." I have read and understand all the provisions specified in this policy.
Initial _____

Employee Time Clock Use Policy (applicable only to hourly employees working in Parks & Recreation, at the Cranberry Highlands Golf Course, and part-time Customer Service positions)

I hereby acknowledge that I have received a copy of the "Employee Time Clock Use Policy." If I am in a position that utilizes a time clock, I have read and understand all the provisions specified in this policy.

Initial _____(if this policy does not apply to you, please enter N/A in this field)

FMLA Policy

I hereby acknowledge that I have received a copy of the "Family & Medical Leave Act Policy." I have read and understand all the provisions specified in this policy. *This policy may not be applicable based on employment status. Union contracts may vary; refer to union contract if applicable.

Initial _____

Township Policies

I hereby acknowledge there are more Township policies than described above and further acknowledge I have been made aware of where to locate all Township policies.

Initial _____

_____ _____

Employee Signature Date

_____

Print Name

For Use Beginning August 23, 1996

WORKERS' COMPENSATION EMPLOYEE NOTIFICATION

The Workers' Compensation Act is designed to provide reimbursement for reasonable medical care for someone who suffers an injury arising in the course of his employment and causally related thereto. Pursuant to the Act, your employer will provide payment for reasonable surgical and medical services, services rendered by physicians or other health care providers, medicines and supplies, as and when needed.

If you require emergency medical treatment, you may seek it from any provider, however, any subsequent non-emergency treatment shall be obtained from one of the designated health care providers whose names appear on the list posted on your employer's premises. You must obtain treatment from one of these providers for ninety (90) days from the date of your first visit to that provider; otherwise, your employer shall not be responsible for payment of your non-emergency medical bills for that first ninety (90) days.

During the initial ninety (90) days from the date of your first visit, you have the right to switch from one health care provider on the list to another and that treatment will be paid for by your employer.

If a designated health care provider refers you for treatment to another health care provider whose name is not on the list, your employer will pay for treatment rendered by the provider whom you were referred.

Naturally, you have the right to seek treatment or medical consultation from a non-designated health care provider during the initial ninety (90) day period following the first visit, but you are personally responsible for payment for those services.

You have the right to seek treatment from any health care provider at the expiration of the ninety (90) day period from the date of first visit. This treatment will be paid for by your employer unless the treatment is found to be unreasonable or unnecessary by a utilization review organization pursuant to the utilization review process contained in the Pennsylvania Workers' Compensation Act.

Your employer will be responsible for the cost of that treatment after the initial ninety (90) day period has ended but only if you notify the employer that you are receiving treatment from a non-designated health care provider and only if that notice is provided to your employer within five (5) days after the first visit to that provider. If you provide notice to your employer of treatment by a non-designated provider more that five (5) days after the first visit to that provider, the employer will not be responsible to pay for treatment rendered by that non-designated provider until it receives notification from you that you are receiving such treatment.

Should invasive surgery be prescribed by a designated health care provider, your employer will pay for an additional opinion from a health care provider of your choice. If the additional opinion differs from the opinion of the designated health care provider and if the additional opinion provides a specific and detailed course of treatment, you will then determine which course of treatment to follow. If you choose to follow the procedures recommended in the additional opinion, your employer will pay to have such procedures performed by one of its designated health care providers and will not be responsible for payment for treatment provided by a non-designated provider for a period of ninety (90) days from the date of your visit to the health care provider from whom you obtained the additional opinion.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AND UNDERSTAND MY RIGHTS AND DUTIES UNDER THE WORKER'S COMPENSATION ACT AS SET FORTH HEREIN.

DATE: _____ _____

Employee Signature

EMPLOYEE RE-NOTIFICATION

I hereby acknowledge that I have been informed again and that I understand my rights and duties under the Worker's Compensation Act. I have received a copy of this Worker's Compensation employee notification form.

DATE: _____ _____

Employee Signature

Workers' Compensation Information

The following information is being provided to you in compliance with 34 Pa.Code § 121.3b.

1) The workers' compensation law provides wage loss and medical benefits to employees who cannot work, or who need medical care, because of a work-related injury.

2) Benefits are required to be paid by your employer when self-insured, 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 and at its sites of employment in a prominent and easily accessible place, including, without limitation, areas used for the treatment of injured employees or for the administration of first aid.

3) You should report immediately any injury or work-related illness to your employer.

4) Your benefits could be delayed or denied if you do not notify your employer immediately.

5) If your claim is denied by your employer, you have the right to request a hearing before a workers' compensation judge.

6) The Bureau of Workers' Compensation cannot provide legal advice. However, you may contact the Bureau of Workers' Compensation for additional general information at: Bureau of Workers' Compensation, 1171 South Cameron Street, Room 103, Harrisburg, Pennsylvania 17104-2501; telephone number within Pennsylvania (800) 482-2383; telephone number outside of this Commonwealth (717) 772-4447; TTY (800) 362-4228 (for hearing and speech impaired only); www.state.pa.us, PA Keyword: workers comp.

Employee's Signature: _____

Date: _____