

Midwestern Intermediate Unit IV
453 Maple Street
Grove City, PA 16127-2399

To: Midwestern IU IV Employees

From: Brenda A. Marino, Esquire
Assistant to the Executive Director

Subject: Workers' Compensation

Date: May 1, 2026

Please follow the guidelines below if you are involved in a work-related injury or illness.

Every work-related injury or illness must be reported immediately to your supervisor and Jennifer Hedglin, Executive Secretary (724) 458-6700, ext. 1203, email claim form to jennifer.hedglin@miu4.org or fax at 724-458-5083.

In this packet you will find instructions, information, and the required forms to complete to successfully and efficiently submit your Workers' Compensation claim.

- Attachment 1 – **Encova Online Services Claim Filing:** Complete this form and immediately mail, email or fax to Jennifer Hedglin at the MIU IV office.
- Attachment 2 - **Accident/Incident Form:** To be completed by your immediate supervisor with your input. Mail, email or fax to Jennifer Hedglin at the MIU IV office.
- Attachment 3- **Information and instructions to guide you through the Workers' Compensation process.**
- Attachment 4- **Butler County list of medical providers**
- Attachment 5- **Mercer & Lawrence County list of medical providers**
- Attachment 6- **Employee Acknowledgement:** Complete and sign this form to acknowledge that you have read and understand your rights and duties under the Pennsylvania Workers' Compensation Act. Mail, email or fax the completed acknowledge to Jennifer Hedglin at the MIU IV office.
- Attachment 7- **Physician Statement of Physical Capabilities:** You must have the designated physician complete this form each time you are at a scheduled visit for your Workers' Compensation injury/illness. Email or fax the form to Jennifer Hedglin at the MIU IV office.
- Attachment 8- **Medical Records Release:** Complete this form authorizing all health care providers and/or insurance companies related to your Workers' Compensation injury/illness to release the information on this form. Email or fax the form to Jennifer Hedglin at the MIU IV office.
- Attachment 9- **First Fill Information for Pharmacy.**
- Attachment 10- **Medical Treatment Waiver Form:** If you do not require medical treatment for your Workers; Compensation injury/illness, complete this form and mail, email or fax to Jennifer Hedglin at the MIU IV office.

1. Complete the **Encova** online Services Claim Filing (Attachment 1) and immediately email to jennifer.hedglin@miu4.org or fax the form to 724-458-5083 at the MIU IV office.
2. The Accident /Incident Investigation form (Attachment 2) should be completed by your supervisor with your input. The form should be emailed or faxed to Jennifer Hedglin at Midwestern Intermediate Unit IV office immediately.
3. If it is necessary for you to seek medical treatment, schedule an appointment with a designated physician (Attachments 4, 5 or 6).

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 PANEL'S DESIGNATED PHYSICIANS AS LISTED ON ATTACHMENTS 4, 5 OR 6.

YOU MUST CONTINUE TO VISIT ONE OF THE DESIGNATED PHYSICIANS FOR NINETY (90) DAYS FROM THE DATE OF YOUR FIRST VISIT. IF YOU DO NOT COMPLY WITH THIS REQUIREMENT, YOUR EMPLOYER WILL BE RELIEVED FROM LIABILITY FOR PAYMENT OF SERVICES RENDERED DURING THIS PERIOD.

4. If you do seek medical treatment, the designated physician must complete the Physician Statement of Physical Capabilities for each office visit related to your Workers' Compensation injury (Attachment 8). In addition, you will need to read, sign and date the Medical Records Release form (Attachment 9).
5. Prescription(s) for a work injury or illness may be filled at any of the pharmacies listed on Attachment 11. Present the temporary National Pharmaceutical Services Authorization Card to the pharmacist prior to having your prescription filled. The card is valid for seven (7) days only and allows you to obtain the prescribed medication at no cost to you.
6. For Physical Therapy and/or Diagnostic Testing (MRI, CT-Scans, etc.), call Premier Comp Solutions at **1-888-594-4001**. Facilities are available based on geographical areas. Premier Comp Solutions will make the appointment for you.
7. If an employee is injured during the regular work day and the injury requires the employee to leave his/her work assignment to obtain medical treatment from one of the designated physicians and the employee provides the employer with a Work/Activity Status Form (attachment 8) completed by a designated physician the employee will not be expected to use a sick day, personal day or an unpaid day.
8. If the employee is injured and seeks treatment and based on the designated physician's recommendation, is able to return to his/her assignment once treatment is completed **ON THE DAY OF INJURY**, then the employee is expected to do so accordingly.
9. If the injured employee is unable to return to work for a period of 14 days or more and receives compensation for lost wages **UNDER THE WORKERS' COMPENSATION LAW**, then the employee is expected to reimburse the employer for time lost on the date of injury.
10. If you are required to be off work during the first seven days after a work-related incident, you will be required to use sick, personal or vacation days. If you do not have any remaining compensated days, you will be required to take the first seven days unpaid until such time as any workers' compensation work lost benefits are approved by Encova Insurance.

Compensation for lost wages due to disability is paid beginning with the eighth day of disability. No compensation is paid for the first seven days unless the period lasts 14 days or more, in which event the employee also receives compensation for the first seven days of disability.

11. Midwestern Intermediate Unit IV's Board Policy regarding workers' compensation and sick leave is as follows: **WORKERS' COMPENSATION AND SICK LEAVE**

Per MIU IV Bargaining Unit agreements regarding job-related injuries for which the employee is entitled to Workers' Compensation gives the employee an option of:

1. Collecting his/her Workers' Compensation and pay but losing sick days for all time off,

OR
2. Be paid for all days off but not be charged sick days provided the Intermediate Unit receives the payment from the carrier of the Workers' Compensation, and provided the number of days lost does not exceed accumulative sick days,

OR
3. Collecting only his/her Workers' Compensation. An employee choosing this option shall receive no pay from the Intermediate Unit nor shall his/her accumulated sick leave be in any manner affected.

Should it become necessary for you to complete an option selection form, a form will be sent to you at that time.

12. If for any reason your claim is denied, you have rights under the Worker's Compensation law. Please read, sign, date and send the Acknowledgement of Rights form (Attachment 7) to Jennifer Hedglin at jennifer.hedglin@miu4.org or fax -724-458-5083
13. If you have any questions regarding the information contained in this memo, please contact Jennifer Hedglin at 724-458-6700, ext. 1203, or Brenda Marino (Assistant to the Executive Director) at 724-458-6700, ext. 1204. If you have questions regarding your claim, medical treatment or work loss, please contact Encova Insurance at (866-452-7425) You should be assigned a claim number and a claim's adjuster within 24-48 hours of MIU IV's Human Resource Office reporting the incident.

If your injury occurs after IU office hours and you wish to file the claim through the answering service, there is a Claim Intake Unit that will handle calling in claims from 8AM-5PM M-F. After hours it transfers to the Customer Service Vendor Intake Rep. The form is attached to this packet. If you choose to use this method, you still have to notify the IU to report the claim and complete all necessary paper work. **Encova Answering Service (866)452-7425**

EMPLOYEE'S ACKNOWLEDGEMENT FORM UNDER SECTION 306(f)(1)(i) OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

I recognize and agree that my employer has provided a list of at least six (6) designated health care providers, no more than two (2) of whom are coordinated care organizations and no fewer than three (3) of whom are physicians. Therefore, I acknowledge that I must treat with one of these health care providers for ninety (90) days from the date of my first visit. If I fail to treat with one of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this ninety (90) day period. Subsequent treatment may be provided by any health care provider of my choice. However, I must advise my employer within five (5) days of my first visit to each and every non-designated health care provider. Failure to do so may affect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties and my signature acknowledges that I have been so informed and that I understand my rights and duties.

REQUIRED NOTICE OF EMPLOYEE RIGHTS AND DUTIES

1. The employee has the duty to obtain treatment for work-related injuries or illnesses from one or more of the designated health care providers for 90 days from the date of the first visit to a designated provider.
2. The employee has the right to have all reasonable medical supplies and treatment related to the injury paid for by the employer as long as treatment is obtained from a designated provider during the 90-day period.
3. The employee has the right, during this 90-day period, to switch from one health care provider on the list to another provider on the list, and that all the treatment shall be paid for by the employer.
4. The employee has the right to seek treatment from a referral provider if the employee is referred to him by a designated provider, and the employer shall also pay for the treatment rendered by the referral provider.
5. The employee has the right to seek emergency medical treatment from any provider, but that subsequent non-emergency treatment shall be by a designated provider for the remainder of the 90-day period.
6. The employee has the right to seek treatment or medical consultation from a non-designated provider during the 90-day period, but that these services shall be at the employee's expense for the applicable 90 days.
7. The employee has the right to seek treatment from any health care provider after the 90-day period has ended, and that treatment shall be paid for by the employer, if it is reasonable and necessary.
8. The employee has the duty to notify the employer of treatment by a non-designated provider within 5 days of the first visit to that provider. The employer may not be required to pay for treatment rendered by a non-designated provider prior to receiving this notification. However, the employer shall pay for these services once notified, unless that treatment is found to be unreasonable by a URO, under Subchapter C (relating to medical treatment review).
9. The employee has the right to seek an additional opinion from any health care provider of the employee's choice when a designated provider prescribes invasive surgery for the employee. If the additional opinion differs from the opinion of the designated provider and the additional opinion provides a specific and detailed course of treatment, the employee shall determine which course of treatment to follow. If the employee opts to follow the course of treatment outlined by the additional opinion, the treatment shall be performed by one of the health care providers on the employer's designated list for 90 days from the date of the first visit to the provider of the additional opinion.

Employee's Signature

Date

Employee's Name (Print)

Employer

Witness' Signature

Date

Fax this form to Jennifer Hedglin at 724-458-5083 or email to jennifer.hedglin@miu4.org.

encova CLAIM FILING FORM

INSURANCE

(Compatible with StreetConnect claim filing and OSHA Form 301 filing)

* Denotes required field

Please note: The fields highlighted in grey are pre-populated in the online system.

Date of Injury: *	Policy number:	Policy name:	Case # from OSHA Log (if applicable):
Filing date:	Claim type: * ☐ Incident ☐ Indemnity ☐ Medical only	Jurisdiction:	

What is your name? *	What is your job title?
What is your telephone number? *	What is your fax number?
What is your email address?	If no, who should we contact for additional information?
Are you the contact for this claim? ☐ No ☐ Yes	What is the contact's phone number?
What is the contact's email?	What is the contact's email?
Is this a Federal Longshore (USL&H) claim? ☐ No ☐ Yes	Are you reporting a fatality? ☐ No ☐ Yes
Date of Injury/date of last exposure: *	Date of death: *
What is the employee's ID type? *	What is your policy number? *
☐ Employment Visa number ☐ Green Card number ☐ Passport number ☐ Social Security number	ID number: *
What is the employee's name? First: *	MI: Last: * Suffix:
What is the employee's mailing address? Street/P.O. Box: *	
Zip: *	City: * State: * Country:
What is the employee's physical address? Street/P.O. Box:	
Zip:	City: State: Country:
What is the employee's primary telephone number?	What is the employee's alternate telephone number?
What is the employee's regular work schedule?	

What is the employee's date of birth? *	Gender: * ☐ Male ☐ Female ☐ Unknown
Marital status: * ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common law ☐ Unknown	
What is the Industrial code? *	What is the job title? *
Description of employee's job and regular duties:	

Demographic / Wage Questions

What is the employee's hire date? *

What is the state of hire for this employee?

Employment type: ☐ Full-Time ☐ Part-Time ☐ Volunteer

Is the employee: An officer? ☐ No ☐ Yes
An owner/part owner? ☐ No ☐ Yes

What is the hourly rate of pay for this employee?

What are the number of hours worked per week for this employee?

What is the daily rate of pay for this employee?

How many hours per day did the employee work?

How many days per week did the employee work?

Is there any additional wage information not included in the daily rate (i.e. commissions, etc.)?

Is the employee continuing to receive full wages? ☐ No ☐ Yes

What is the primary work location? *

Name:

Address: *

Country:

Zip: *

City: *

State: *

What is the reporting location?

Did the accident occur on the employer's property? * ☐ No ☐ Yes

If no, where did the accident occur? *

Address:

Name: *

Zip:

City:

State:

Country:

Was this the employee's regular department? ☐ No ☐ Yes

In what department did the accident occur?

Was injury the result of a motor vehicle accident? ☐ No ☐ Yes

Was any equipment involved in the injury? ☐ No ☐ Yes
If yes, what equipment?

What was the employee doing just before the incident occurred?

How did the accident occur? *

What object or substance directly harmed the employee?

Was safety equipment provided? ☐ No ☐ Yes

Was safety equipment used? ☐ No ☐ Yes

If yes, what type?

What was the injured body part(s)? *

What is the body part location? * ☐ Bilateral ☐ Left ☐ Lower ☐ Middle ☐ Right ☐ Upper ☐ Not applicable

What is the nature of the injury (sprain, strain, etc.)? *

What was the cause of injury? *

Are you aware of a previous injury to this body part? * ☐ No ☐ Yes

If yes, please explain: *

Do you have knowledge of pre-existing disability, industrial or non-industrial? ☐ No ☐ Yes

If yes, please explain: *

Are there outside activities or medical conditions that would affect this injury? ☐ No ☐ Yes

If yes, please explain: *

Demographic Questions

List all others involved in the accident with contact information:

1.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			
2.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			
3.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			

List all witnesses to the accident (or enter "none"):

1.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			
2.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			
3.	First name:	MI:	Last name:
Address:			
Zip:	City:	State:	Country:
Phone:			

What time did the employee begin work? * (Include a.m. or p.m.)

What time did the accident occur? * (Include a.m. or p.m.)

Who was notified of the accident?

When did the injured worker notify the employer? * (Date)

Did the claimant stop work? ☐ No ☐ Yes

What is the loss type?

☐ Incident only ☐ Indemnity ☐ Medical only ☐ Modified duty with no wage loss ☐ Modified duty with wage loss

What was the last date worked?

What time did the employee stop work? (Include a.m. or p.m.)

Has the employee returned to work? ☐ No ☐ Yes

Date of return to work?

Did/will the claimant return to full duty? ☐ No ☐ Yes

Do you have transitional/modified work available? ☐ No ☐ Yes

Number of hours per week?

Modified daily rate of pay?

Was medical treatment provided? ☐ No ☐ Yes

Name of medical provider:

Medical facility/provider's address:

Zip:

City:

State:

Country:

Was employee treated in an emergency room? ☐ No ☐ Yes

Was employee hospitalized overnight as an in-patient?
☐ No ☐ Yes

What was the method of transportation? ☐ Helicopter ☐ Ambulance ☐ Personal vehicle ☐ Other

Do you require your employees to be drug tested? ☐ No ☐ Yes

If yes, when was the employee last tested?

Was an Incident report completed? * ☐ No ☐ Yes

Do you have any reason to question this injury? * ☐ No ☐ Yes

Do you have any comments for the record?

PHYSICIAN STATEMENT OF PHYSICAL ABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name:	Claimant number:	Date of injury:
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Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis:

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Standing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐

>67% of workday 34% - 66% of workday 6% - 33% of workday <5% of workday 0% of workday

Please indicate the extent to which the employee can perform the following:
 (C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

Activity	C	F	O	R	N
Lifting/carrying					
5 lbs. or less					
5-10 lbs.					
11-20 lbs.					
21-40 lbs.					
41-60 lbs.					
61-100 lbs.					
100+ lbs.					
Driving					
Automatic drive					
Standard drive					
Upper extremities					
Simple grasping	☐ Right	☐ Left	☐ Right	☐ Left	
Pushing/pulling	☐ Right	☐ Left	☐ Right	☐ Left	
Lower extremities					
Operate foot controls	☐ Right	☐ Left	☐ Right	☐ Left	
Simultaneous	☐ Yes	☐ No			
Vibration					

Comments:

Physician name:	Physician telephone:
Date released with above restrictions:	Date released for full-duty work:
Projected date for MMI:	Date and time of next appointment:
Physician signature:	Date:



Midwestern Intermediate Unit # 4 - Mercer County-Lawrence County

Your Workers' Compensation Insurance Carrier is:

Encova Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. 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 for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Area of Specialty</u>
UPMC GoHealth Urgent Care (Multiple Locations)	1729 East State Street Hermitage, PA 16148	724-418-4634	Urgent Care/Occupational Medicine
BHS Seneca Medical Center - Workers Care (Multiple locations)	208 Butler Street Clintonville, PA 16372	814-677-1768	Occupational Medicine
Sharon Regional Corporate Health	2435 Garden Way Hermitage, PA 16148	724-346-6425	Occupational Medicine
Allegheny Orthopaedic Associates - The Orthopaedic Institute (Multiple Locations)	647 North Broad Street Ext Suite 206 Grove City, PA 16127	724-264-4864	Orthopedics
Sharon Regional Health System General Surgery Sharon Regional	2425 Garden Way, Suite 101 Hermitage, PA 16148	724-981-0630	General Surgery
UPMC Mercy Neurosurgery (Multiple Locations)	1350 Locust Street, Suite 300 Pittsburgh, PA 15219	412-471-4772	Neurosurgery
Laurel Eye Clinic (Multiple Locations)	217 South Broad Street Grove City, PA 16127	800-494-2020	Ophthalmology

CONVENIENT NETWORK LOCATIONS LISTED BELOW

PCS PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
PCS Diagnostic Network	Call Toll Free for Closest Location	1-888-594-4001	Diagnostic Testing
Mitchell ScriptAdvisor	Call Toll Free for Closest Location	1-866-846-9279	Pharmacy

Panel Date: 4/28/2026



Midwestern Intermediate Unit # 4 - Butler County

Your Workers' Compensation Insurance Carrier is:

Encova Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. 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 prosthesis, including training in their use.
2. In order to ensure that your medical treatment will be paid for by your employer or its insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. 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 for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Area of Specialty</u>
UPMC GoHealth Urgent Care (Multiple Locations)	256 New Castle Road Butler, PA 16001	724-283-3627	Urgent Care/Occupational Medicine
HealthWorks at Allegheny Valley Hospital	1301 Carlisle Street Natrona Heights, PA 15065	724-226-7045	Occupational Medicine
Tri Rivers Musculoskeletal Centers - Physiatry (Multiple Locations)	142 Clearview Circle Butler, PA 16001	866-874-7483	Physiatry
Tri-State Orthopaedics & Sports Medicine (Multiple Locations)	400 Northpointe Circle, Suite 101 Seven Fields, PA 16046	412-369-4000	Orthopedics
Tri Rivers Musculoskeletal Centers - Orthopedics (Multiple Locations)	142 Clearview Circle Butler, PA 16001	866-874-7483	Orthopedics
Independence Health System	129 Oneida Valley Road, Suite 111 Butler, PA 16001	833-995-0116	General Surgery
UPMC Mercy Neurosurgery (Multiple Locations)	1350 Locust Street, Suite 300 Pittsburgh, PA 15219	412-471-4772	Neurosurgery
Scott, Christie & Associates (Multiple Locations)	105 Brandt Drive, Suite 201 Cranberry Township, PA 16066	724-772-5420	Ophthalmology

CONVENIENT NETWORK LOCATIONS LISTED BELOW

PCS PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
PCS Diagnostic Network	Call Toll Free for Closest Location	1-888-594-4001	Diagnostic Testing
Mitchell ScriptAdvisor	Call Toll Free for Closest Location	1-866-846-9279	Pharmacy

Panel Date: 4/28/2026

INJURED EMPLOYEE CHECKLIST



Report all injuries to supervisor

(Alabama, Georgia, Indiana, Iowa, Kansas, Missouri, North Carolina, Pennsylvania, South Carolina, Tennessee and Virginia allow your employer to either choose your physician or provide you with a list of approved physicians)



Obtain either a full-duty release or a completed Physician Statement of Physical Capabilities Form from the doctor (if released for light/modified duty)



If released to return to work, return on your next scheduled work day with either your full-duty release or the Physician Statement of Physical Capabilities Form



If not released to return to work, you must call your supervisor within one business day and provide:

- Physician's name, address and phone number
- Date of your next scheduled doctor appointment



Return Incident Report to your supervisor upon return or within 24 hours