District Name: Tomball ISD

EMPLOYEE REPORT OF INJURY INCIDENT

PRINT all information on this form.
This checklist is to be completed by the INJURED EMPLOYEE with assistance from his/her immediate supervisor as necessary.
This packet is VERY TIME SENSITIVE.
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the injured employee and the supervisor.
This form must be included in the Incident Investigation Packet submitted to *SchoolComp*.

SECTION I: EMPLOYEE PERSONAL INFORMATION

First Name, Middle Initial, Last Name:			**SS#:**
Male Female	**Date of Birth: (Mo, Day, Yr)**		**Married Single Divorced**
Ethnicity: Hispanic Native American Other		**Race: Asian Black White**	**Home Phone #:**
Home Address: - _____ _____, **TX** _____			**Cell Phone #:**
Spouses Name:	**Email Address:**		**# Dependent Children:**

SECTION II: INJURY INCIDENT INFORMATION

Work Location:	**Job at Time of Incident:**	
Date of Hire:	**Work Phone #:**	**Best Time to Call:**
Date of Incident: (Month, Day, Year)	**Day of Week: (Mon, Tue, Wed....)**	**Time of Day: AM PM**
Exact Location of Incident: (Football field, classroom, cafeteria, etc. Please be specific)		
Detailed Description of Incident (In Your OWN Words) :		
Print Name of Supervisor:		
Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC)		
Names of ALL Witnesses:		
Did you seek treatment from a clinic, hospital, or doctor for this injury? Yes No		**When?**
Name of Treating Physician:	**Physician's Phone #:**	

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize any and all providers of medical treatment deemed necessary in regard to my reported occupational injury or illness to release any medical information acquired in the course of my treatment to my employer and Creative Risk Funding, Inc.

Employee Signature	Date
Supervisor Signature	Date

SchoolComp - Self Insured Workers= Compensation Program
Administered by **Creative Risk Funding, Inc.**
6100 W Plano Pkwy, Ste 1500, Plano, Texas 75093
Phone 972.889.9300 Toll Free 888.230.9300 Fax 972.889.3700

District Name: Tomball ISD

WITNESS REPORT OF EMPLOYEE INJURY

PRINT all information on this form. This is to be completed by **any** witness to an employee injury.
This form should be completed **INDEPENDENTLY**, with no conversation between the witness and the injured employee.
This Witness Report is VERY TIME-SENSITIVE.
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be given to the supervisor of the injured employee for inclusion in their Incident Investigation Packet submitted to ***SchoolComp***.

Name of Injured Employee:		Name of Witness Completing Report:
Date of Incident:	Day-of-the-Week:	Time of Incident: AM PM
Location of Incident:		
Specific Body Part Injured: (left arm, right elbow, etc.)		
Description of Injury:		

Detailed Description of Incident:
Did the employee do anything, or fail to do anything that contributed to the injury? Yes No
If Yes, please explain:
In your opinion, how could this injury have been prevented?
List any other witnesses that were present at the time of the injury incident:

I hereby certify that the above information is true and correct to the best of my knowledge. I will provide further information about this incident to my employer or Creative Risk Funding, Inc. at any time.

Witness Signature:	Date:	Printed Name:
Supervisor Signature:	Date:	Printed Name:

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District Name:	Tomball ISD

IMMEDIATE SUPERVISOR REPORT OF EMPLOYEE INJURY

PRINT all information on this form.
This is to be completed by the immediate supervisor of the injured employee.
This packet is VERY TIME SENSITIVE.
The Supervisor Report should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the supervisor.
This form must be included in the Incident Investigation Packet forwarded to the Workers' Compensation Coordinator at the district and must be submitted to *SchoolComp*.

Name of Injured Employee:	**Job Title:**
Date and Time this Incident was Reported to You:	
To what specific task was the worker assigned at the time of the incident?	
Was the assigned task part of the employee's regular job?	
If NO, please explain:	
List safety equipment needed for this task:	
Was safety equipment being used by the injured worker at the time of the incident?	

Date of Incident: **(Month, Day, Year)**	**Day of Week:** **(Mon, Tue, Wed....)**	**Time of Day: _____ AM PM**
Exact Location of Incident: **(Football field, classroom, cafeteria, etc. Please <u>be SPECIFIC</u>)**		
<u>Detailed</u> Description of Incident (In Your OWN Words):		
Specific Body Part Injured: **(Left leg, right hand, etc. Please be <u>SPECIFIC</u>)**		
Did the employee do anything, or fail to do anything that contributed to the injury? If yes, please explain:		

Did employee lose time from work?	**Yes**	**No**	**First date unable to report for work**
Has employee returned to work?	**Yes**	**No**	**If NO, date expected to return**
Were District Safety Rules Violated?	**Yes**	**No**	**If Yes, was Employee Counseled?**
What steps will you take as supervisor to prevent future occurrences of this incident?			

Phone number to reach Supervisor or direct phone number for Supervisor	
<u>Printed</u> Name of Supervisor completing this form	**Position**
Supervisor Signature	**Date**

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District Name:	Tomball ISD

IMPORTANT NOTICE TO MEDICAL PROVIDER

INSTRUCTIONS: This form should be given to the injured worker to present to the medical care provider from whom s/he seeks treatment for work-related injury. Please print all information.

SECTION I: Incident Information

Name of Injured Employee:
Date, Day-of-the-Week, and Time of Incident:
Specific Body Part(s) Affected by this Incident:
Detailed Description of Incident:

DEAR MEDICAL CARE PROVIDER:
The above named employee has reported a work-related injury incident. Our district is a tax-supported public entity, and as such is Self-Insured for the purposes of Workers= Compensation. Our district DOES have a light-duty program. This may allow the injured worker to return to work with restrictions as specified by you with no lost wages to the injured employee. Please supply the injured worker with a **DWC-73 Division of Worker's Compensation Work Status Report** upon completion of initial treatment and evaluation of the injured workers= condition. Thank You.

IMPORTANT HIPAA INFORMATION: Since the implementation of HIPAA regulations, our district has heard concerns from a number of medical providers regarding the release of medical records without specific patient consent, even though it is clear that the information is to be used for workers= compensation utilization and billing issues. Workers= Compensation injuries are specifically excluded from HIPAA regulations, and as a result, no patient consent form is required to release medical information. (Texas Workers= Compensation Commission Advisory 2003-05)

However, as a service to medical providers, we are supplying a Release of Medical Records consent signed by the injured worker. See below. This statement, when signed by the injured worker, releases medical records to the District and Creative Risk Funding (our TPA) for the purpose of managing the claim under Texas Department of Insurance, Division of Workers' Compensation rules.

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I hereby authorize the physician/medical provider to disclose any information to my employer and employer=s agents regarding treatment for my work-related injury. I hereby release the physician/medical provider from any liability arising from such disclosure regarding this and any subsequent follow-up treatment.

Employee Signature	
Date	

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Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system**. If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**