Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name _____Date of Injury _____

Date of Birth_____Social Security _____

Reported Work Related Injury or Illness:

_____

_____

Goose Creek CISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768-2010
Phone: 800.482.7276
Fax: 800.580.6720

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature _____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description enquiries to:

Letty Arredondo, Workers' Compensation Specialist
Phone: 281.707.3705
Fax: 346.216.3000
Email: Leticia.Arredondo@gccisd.net

For a full list of Alliance Providers please visit pswca.org.