EMPLOYEE - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

Employees must immediately notify their supervisor of any injury that occurs while on duty regardless of whether they require medical attention.

- ❑ Complete and sign the **First Report of Injury**.
- ❑ Complete and sign the **Acknowledgement of Medical Alliance**
- ❑ Complete and sign the **Elect Leave benefits with Workers' Compensation**

Forms to be given to employees

- Injured Employee Responsibilities
- Notice of Injured Employee Rights and Responsibilities
- Verification of Employment **(if seeking treatment)**
- OPTUM **(if seeking treatment)**

Email all signed forms and paperwork within 24 hours of incident to:

Letty Arredondo, Benefits Supervisor
Phone: 281.707.3705
Fax: 346.216.3000
Email: Leticia.Arredondo@gccisd.net

Please contact Benefits for any further questions or issues regarding any workers' compensation injury. Alert Letty Arredondo immediately if employee misses any time, returns to work, or if there are any questions or concerns.

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

First Report of Employee Injury

Employee Information

Name:_____ SSN:_____ Date of Birth:_____

Sex:_____ Race:_____ Marital Status:_____

Position:_____ Department/Campus:_____

Home Address:_____ Home/Cell Phone:_____

Description of Incident

Date of Injury:_____ Time of Injury:_____ ☐ am ☐ pm

Nature of Injury (bruise, cut, strain, etc.):_____

Specific Part of Person Injured (left forearm, right foot, etc.):_____

Cause of Injury (fall, slip, struck by, etc.):_____

Object or Substance Involved in Injury (tool, chemical, etc.):_____

Location of Incident:_____

Witnesses to the Incident:_____

Employee's Account of the Incident:_____

_____

_____

Date Reported:_____ Reported to:_____

Additional Information (to be completed by Supervisor)

Supervisor Name:_____ Campus/Department:_____

Employee Date of Hire:_____ ☐ Full-Time ☐Part-Time Rate of Pay:_____ ☐ hourly ☐ daily

Was the employee doing his/her regular job? ☐ Yes ☐ No

Did the incident occur on district property? ☐ Yes ☐ No If yes, location:_____

Did the employee seek medical treatment? ☐ Yes ☐ No If yes, where:_____

Supervisor's Account or Comments:_____

_____

_____

Pursuant to the terms of the Medical Practices Act, I hereby consent to any physician's release to my employer or its authorized representatives of any and all information or medical records, confidential or otherwise, which he may acquire in the course of my examination or treatment. The reason or purpose for this release is my employer's payments to me, supplemental or sick pay, medical or other benefits, investigation of my medical condition, or other purposes related to my employment.

In the event of any overpayment or underpayment to me, I authorize Goose Creek CISD, without separate notice, to make any adjustments to my pay in subsequent pay periods for errors incurred during preceding pay periods.

Notify your supervisor immediately if injury required physician's care. Falsification of any portion of this report may result in termination.

Employee Signature:_____ Date:_____

Supervisor Signature:_____ Date:_____

GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

EMPLOYEE ACKNOWLEDGEMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ _____/_____/_____
Signature Date

_____
Printed Name

I live at: _____
Street Address City, State, Zip Code

Name of Employer: Goose Creek CISD
Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at **pswca.org** or call your adjuster at 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:
- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.

GOOSE CREEK CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

To Elect Leave Benefits with Workers' Compensation

Employee Information

Name: _____ Employee Number: _____

Position: _____ Department/Campus: _____

This employee is absent from duty because of a job-related illness or injury beginning on _____ (date of first absence attributable to illness or injury). If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

Authorized signature: _____ Date: _____

Benefits Election

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on paid leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on unpaid leave that is not FMLA leave. I choose the following option:

- ☐ I choose to use only _____ days of available paid leave at this time.
- ☐ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness/injury wage.
- ☐ I choose not to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Goose Creek CISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

Employee signature: _____ Date: _____

For office use only

Amount of leave paid to employee: $_____

Daily rate: $_____ or Hourly rate: $_____ / # of hours paid: _____

Period of payment: from _____/_____/_____ to _____/_____/_____ for _____ days or _____ weeks

Letty Arredondo
BENEFITS SUPERVISOR

Leticia.Arredondo@gccisd.net
Office: 281.707.3705 • Fax: 346.216.3000

Workers' Compensation - Employee Responsibilities

Accidents on Duty

When an employee (full-time, part-time, temp, sub) has an accident and is injured in any manner while on duty, the employee must immediately report the accident/incident to his/her supervisor. The supervisor will report the accident/incident to the school secretary or designated person to file the report.

IN CASE OF AN ACCIDENT OR INJURY, PLEASE FOLLOW THESE STEPS:

☐ **Report the Injury**
Employees must immediately notify their supervisor of any injury that occurs while on duty – regardless of whether they require medical attention. Complete the injury report **within 24 hours** of accident/illness.

☐ **Complete the Injury Report Forms with your Campus/Department Secretary or Designee** (forms can be found in the employee packets titled Employee Packets-Record Only or If Needing Medical Attention)
1. Complete and sign the Goose Creek CISD Report of Injury.
2. Complete and sign the Employee Acknowledgement of the Alliance.
3. Complete and sign the Elect Leave Benefits with Worker's Compensation Form.

☐ **If Employee Needs to Seek Medical Attention**
*Goose Creek CISD has chosen, the Political Subdivision of Worker's Compensation Alliance (the Alliance) to manage the health care and treatment of employees who are injured at work.
*For emergencies, employees may go to the nearest emergency room.
*For non-emergencies, employees may be seen at the GCCISD Employee Wellness Clinic. If seeking treatment after hours, employees must select a treating physician from the Alliance Provider Network listed at www.pswca.org.
*Employees are responsible for informing the treating physician of their current job duties.

ADDITIONAL ITEMS

☐ **Restrictions**
After seeking medical treatment, the employee must submit a DWC-73 Work Status Report after **each follow-up** to the Benefits Supervisor until the employee receives a full release to return to work. If the employee is released to return to work with restrictions, the campus / department administrator and the Benefits Supervisor will determine if accommodations can be made.

☐ **Time Lost**
* In the event that an employee is unable to return to work due to an injury, the employee must immediately notify their supervisor and the Benefits Supervisor.
* Employee must advise the Benefits Supervisor if they wish to use their available leave for their absence(s) via the Leave Election Form. If this form is not received, the employee will be docked, and not receive pay for any absences taken after their injury.
* Employee must notify the Benefits Supervisor on current work status immediately following each check-up with the treating physician until the employee obtains a complete release from treatment.

If no medical treatment is desired or needed, a report for the incident/accident will still need to be made and the Employee Packet-Record Only will need to be completed.

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.**

PAGES 9 & 10 TO BE GIVEN TO EMPLOYEES IF SEEKING TREATMENT

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, Benefits Supervisor
Phone: 281.707.3705
Fax: 346.216.3000
Email: Leticia.Arredondo@gccisd.net

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

OPTUM®
PO Box 152539
Tampa, FL 33684-2539

TASB™ RISK FUND

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1813-37