



Rio Brazos Education Cooperative

P.O. Box 1970 - 2400 Franklin Avenue
Waco, Texas 76703
Voice (254) 756-1974 Fax (254) 756-7902

Bridging Together for Educational Excellence

Ben Saage
Executive Director

Workers Compensation Insurance is handled through School Comp which is the carrier for West ISD, our fiscal agent. If you have any questions concerning the filing of a worker's compensation claim, please call Jeane Gauer at (254) 756-0406. She is the coordinator for worker's compensation issues and can assist you in the proper completion of the forms and the deadlines that need to be followed in the submission of a claim. All required forms and notices follow this note below.

Send the specified copies to:
Creative Risk Funding
8111 LBJ Frwy, Ste 795
Dallas, TX 75251 and the injured employee.

Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

| | | | |
|--|----------------------|--|--------|
| 1. Name (Last, First, M.I.) | | 2. Sex F <input type="checkbox"/> M <input type="checkbox"/> | |
| 3. Social Security Number | 4. Home Phone () | 5. Date of Birth (m-d-y) | |
| 6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> | | 8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> | |
| 9. Mailing Address Street or P.O. Box | | | |
| City | State | Zip Code | County |
| 10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> | | | |
| 11. Number of Dependent Children | | 12. Spouse's Name | |
| Doctor's Name | | | |
| 14. Doctor's Mailing Address (Street or P.O.Box) | | | |
| City | State | Zip Code | |

| | | | |
|--|---|---|---------------------------|
| 15. Date of Injury (m-d-y) | 16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/> | 17. Date Lost Time Began (m-d-y) | |
| 18. Nature of Injury* | | 19. Part of Body Injured or Exposed* | |
| 20. How and Why Injury/Illness Occurred* | | | |
| 21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. Worksite Location of Injury (stairs, dock, etc.)* | |
| 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site | | | |
| Street or P.O. Box | | County | |
| City | State | Zip Code | |
| 24. Cause of Injury(fall, tool, machine, etc.)* | | | |
| 25. List Witnesses | | | |
| 26. Return to work date/or expected (m-d-y) | 27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> | 28. Supervisor's Name | 29. Date Reported (m-d-y) |

| | | | |
|--|--|---|---|
| 30. Date of Hire (m-d-y) | 31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/> | 32. Length of Service in Current Position Months _____ Years _____ | 33. Length of Service in Occupation Months _____ Years _____ |
| 34. Employee Payroll Classification Code | | 35. Occupation of Injured Worker | |
| 36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly | 37. Full Work Week is: _____ Hours _____ Days | 38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days | 39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/> |

| | | | |
|--|---|--|------------------------------------|
| 40. Name and Title of Person Completing Form | | 41. Name of Business West ISD | |
| 42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone () | | 43. Business Location (if different from mailing address) Number and Street | |
| City | State | Zip Code | City State Zip Code |
| 44. Federal Tax Identification Number | 45. Primary North American Industry Classification System Code:(6 digit) 61110 | 46. Specific NAICS Code (6 digit) | 47. Texas Comptroller Taxpayer No. |
| Workers' Compensation Insurance Company Insured/Texas Public Schools Workers' Compensation Project | | 49. Policy Number | |

50. Did you request accident prevention services in past 12 months?
 YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Employee Rights and Responsibilities Under the Texas Workers' Compensation System

Employers must provide this information to the employee at the time the first report of injury is filed, in two languages: In English and in either Spanish or the language common to the employee

YOUR RIGHTS IN THE TEXAS WORKERS' COMPENSATION SYSTEM

1. You may have the right to receive benefits.

You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefits if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured by another person for personal reasons, you were injured while voluntarily participating in an off-work activity, you were injured by an act of God, or your injury occurred during horseplay.

2. You have the right to receive the medical care reasonable and necessary to treat your work-related injury or illness for the rest of your life.

3. You have the right to the initial choice of doctor.

You may not change doctors except with the approval of the Commission. You do not need to get approval to go to a different doctor for emergency treatment, if you or your doctor moves or if your doctor is unable to continue treating you.

4. You have the right to hire an attorney to help you get benefits or to help you resolve disputes.

5. You have the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding, from a Commission ombudsman free of charge. To request assistance; contact the field office handling your claim, or call 1.800.252.7031.

You have the right to receive information and assistance regarding your claim. Commission staff will explain your rights and responsibilities under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Commission ombudsman in informal dispute resolutions and in administrative proceedings if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you.

6. You have the right to confidentiality.

Only people who need to know such as your doctor, your employer or your employer's insurance carrier may see information in the Commission's files. A prospective employer may get limited information from the commission about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for them to do so.

YOUR RESPONSIBILITIES UNDER THE TEXAS WORKERS' COMPENSATION SYSTEM

1. You have the responsibility to tell your employer about your injury or illness.

You must tell your employer **within 30 days** of the date you were injured, or **within 30 days** of the date you first knew your illness might be work-related. You, or someone helping you, may either talk with or write your employer or any supervisor where you work.

If you do not tell your employer within 30 days, you could lose your right to get benefits.

2. You have the responsibility to fill out a claim form and send it to the Commission.

You must send a completed claim form, called a TWCC-41, to the Commission **within one year** of the date you were injured, or **within one year** of the date you first knew your illness might be work-related.

Send the completed claim form to the Commission even if you are already getting benefits.

If you do not send the form within one year, you could lose your right to get benefits. For a copy of the form, call the field office handling your claim, or call 1.800.252.7031.

3. You have the responsibility to tell the Commission and the insurance carrier any time your income changes.

If you are *not* getting benefits and you have changed employers since your injury, tell the Commission if your injury causes you to miss work or lose income. Call 1.800.252.7031

If you *are* getting benefits and you have changed employers since your injury, tell the Commission and the insurance carrier paying your benefits if your income changes. Tell the Commission and the insurance carrier regardless of whether your income went up or down.

If you have stopped working since your injury, tell the Commission and the insurance carrier if you start working again or if you have a job offer.

4. You have the responsibility to tell your doctor how you were injured and if you believe it may be work-related.

If possible, tell the doctor before the doctor treats you.

5. You have the responsibility to tell the Commission and the insurance carrier how to contact you.

You should contact the Commission and the insurance carrier if your home address, work address, or phone number change, so the commission and the insurance carrier will be able to contact you when necessary.

District Name:

WORKERS' COMPENSATION INCIDENT CHECKLIST

PRINT all information on this form.

This checklist is to be completed by the IMMEDIATE SUPERVISOR of the injured employee.

This packet is VERY TIME-SENSITIVE.

All forms in the packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence. Once this form and all other forms in the package have been completed, please forward the entire package to the person in your district responsible for reporting the incident to **SchoolComp**.

SECTION I: Incident Information (Please Print Legibly)

| |
|---|
| Name of Injured Employee: |
| Date, Day-of-the-Week, and Time of Incident: |
| Name of Immediate Supervisor: |
| Detailed Description of Incident: |
| Has injured employee sought medical treatment for this incident? Yes No |
| If "yes", give healthcare provider's name and phone number: |

SECTION II: Completion of Incident Forms (please initial each blank)

| INITIALS | |
|----------|---|
| | Employee Incident Report completed by injured worker? |
| | All witnesses to the incident completed a Witness Report? |
| | Immediate supervisor completed Supervisor's Report? |
| | Notice to Healthcare Provider given to injured employee? |

| | |
|--|--|
| Signature of Person Completing this Form | |
| Date Form Completed | |

SchoolComp - Self Insured Workers' Compensation Program

administered by Creative Risk Funding, Inc.

8111 LBJ Frwy, Ste 795, Dallas, Texas 75251

Phone 972.889.9300 Toll Free 888.230.9300 Fax 972.889.3700

District Name:

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: | | | Cell Phone # | | |
| Spouse's 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 | <input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 |

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District Name:

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: | <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Location of Incident | | | |
| Specific Body Part Injured (left arm, right elbow, etc.) | | | |
| Description of <u>Injury</u> | | | |
| Detailed Description of Incident: | | | |
| Did the employee do anything, or fail to do anything that contributed to the injury? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

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 | <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Exact Location of Incident (Football field, classroom, cafeteria, etc. Please be specific) | | | |
| Detailed Description of Incident (In Your OWN Words) : | | | |
| Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC) | | | |
| 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? | | | |

| | |
|---|----------|
| Printed Name of Supervisor completing this form | Position |
| Supervisor Signature | Date |

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District Name:

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 **TWCC-73 Texas Workers' 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 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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