Work Related Injury

What to do…???

1) Seek medical attention if necessary:
- **a.** First aid kit.
- **b.** Campus nurse
- **c.** Minor clinic/doctor **(Alliance Approved Doctor or Clinic Only)**.
- **d.** Go to emergency room **IF NECESSARY**.
- **e.** Call 911.

2) Complete Work Injury Report - Complete **ALL** white areas.

BE AS SPECIFIC AS POSSIBLE. SIGN AND DATE/HAVE YOUR SUPERVISOR/PRINCIPAL SIGN

3) Complete Employee Acknowledge of the Alliance Direct Contracting Program

4) Read Employee Notice of Alliance Requirements.

Go to www.pswca.org to find an approved medical provider.

5) Send the Work Injury Report and Employee Acknowledgment of the Alliance Direct Contracting Program to Jeanette Revels, Personnel, Central Office.

5) Please note that:
- Only your time for initial treatment at the time of the injury is covered. Sick/Personal (If available) leave may be used for all other time off
- You must notify your supervisor and Jeanette Revels of all appointments.
- You must send copies of all medical records pertaining to the injury to Jeanette Revels, Personnel, Central Office

WORK INJURY REPORT

EMPLOYER NAME	STREET ADDRESS	CITY, STATE	ZIP CODE	EMPLOYER FEIN
Flour Bluff ISD	2505 Waldron Road	Corpus Christi, TX	78418	74-6000593

CARRIER	AGENT
Texas Association of School Boards PO Box 2010, AUSTIN TX 78768 800-482-7276 Fx: 800-580-6720	Texas Association of School Boards

1 NAME (LAST, FIRST)	2 DATE OF BIRTH	3 SOCIAL SECURITY #	4 DATE OF HIRE
	/ /	- -	/ /

5 ADDRESS

6 SEX
- ☐ FEMALE
- ☐ MALE
- ☐ UNKOWN

7 MARITAL STATUS
- ☐ UNMARRIED/SINGLE/DIVORCED
- ☐ MARRIED
- ☐ FEMALE/UNMARRIED
- ☐ UNKOWN

8 CITY	STATE	9 ZIP CODE
	TX	

10 PHONE NUMBER	11 OCCUPATION/JOB TITLE	12 EMPLOYMENT STATUS
( ) -		☐ 10 MONTH ☐ PART TIME ☐ PER DAY ☐ 12 MONTH ☐ FULL TIME $ _____ ☐ PER HOUR

13 TIME EMPLOYEE BEGAN WORK	14 DATE OF INJURY/ILLNESS	15 TIME OF OCCURRENCE	16 LAST WORK DATE	17 DATE EMPLOYER NOTIFIED
: ☐ AM ☐ PM	/ /	: ☐ AM ☐ PM	/ /	/ /

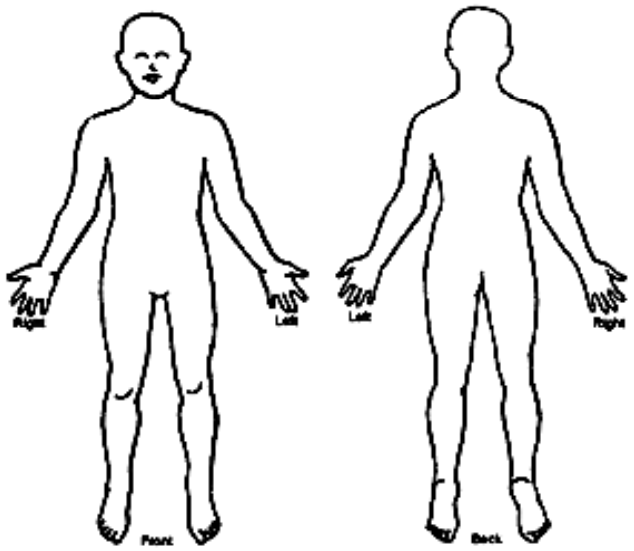
18 TYPE OF INJURY (CHECK ALL THAT APPLY)
- ☐ NO PHYSICAL INJURY
- ☐ BRUISE
- ☐ BURN
- ☐ CONCUSSION
- ☐ CRUSHING
- ☐ DERMATITIS
- ☐ DISLOCATION
- ☐ ELECTRIC SHOCK
- ☐ FOREIGN BODY
- ☐ INFECTION
- ☐ INFLAMMATION
- ☐ LACERATION
- ☐ POISONING - CHEMICAL
- ☐ RESPIRATORY DISORDER
- ☐ SEVERANCE
- ☐ SPRAIN
- ☐ STRAIN

OTHER

19 BUILDING/LOCATION & ROOM #/AREA
- ☐ ATHLETICS ANNEX
- ☐ AUDITORIUM
- ☐ BASEBALL FIELD
- ☐ BUS BARN
- ☐ BUS YARD
- ☐ CARPENTERS SHOP
- ☐ CENTRAL KITCHEN
- ☐ CENTRAL OFFICE
- ☐ CENTRAL PLANT
- ☐ CENTRAL RECEIVING
- ☐ CUSTODIAL WAREHOUSE
- ☐ ECC
- ☐ ELEMENTARY
- ☐ FOOTBALL STADIUM
- ☐ HIGH SCHOOL
- ☐ HVAC FILTER ROOM
- ☐ INTERMEDIATE
- ☐ JUNIOR HIGH
- ☐ MAINTENANCE/TRANSPORTATION
- ☐ OFF SITE
- ☐ PRIMARY
- ☐ RECORDS STORAGE
- ☐ SDGC
- ☐ SOCCER FIELD
- ☐ SOFTBALL FIELD
- ☐ SPECIAL ED
- ☐ TECH WING/PRINT SHOP
- ☐ TENNIS ANNEX
- ☐ UNIVERSITY PREP
- ☐ VARSITY GYM
- ☐ WRANOSKY GYM
- ☐ OTHER: _____

ROOM # OR AREA: _____

20 PARTS OF BODY AFFECTED (CIRCLE ALL AREAS INJURED)



FRONT BACK

21 ALL EQUIPMENT, MATERIALS, OR CHEMICALS BEING USED WHEN INJURY/ILLNESS OCCURRED

22 SPECIFIC ACTIVITY ENGAGED IN WHEN INJURY/ILLNESS OCCURRED

23 HOW INJURY/ILLNESS OCCURRED.

(DESCRIBE THE SEQUENCE OF EVENTS & INCLUDE ANY OBJECTS THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL.)

USE BACK IF NECESSARY.

24 LIST ANY SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED

WERE THEY USED: ☐ YES ☐ NO

WORK INJURY REPORT (Continued)

25 WITNESSES (NAME & PHONE #)	26 TYPE OF TREATMENT
	☐ NO MEDICAL TREATMENT ☐ MINOR BY EMPLOYEE ☐ MINOR BY CLINIC ☐ EMERGENCY CARE

CHOICE OF PHYSICIAN

Under the Texas Workers' Compensation Commission Labor Code *§408.022. SELECTION OF DOCTOR* , "*The employee is entitled to the employee's initial choice of a doctor from the commission's list.* " I understand that Flour Bluff ISD can only refer, not recommend, doctors and/or clinics from the commission's list.

27 PAID LEAVE

In the event an employee is absent from work as a result of a work related injury, Workers' Compensation Weekly Income Benefits do not begin until the eighth (8th) day of absence. Employees may choose to use any accrued leave for the first five (5) work days.

EMPLOYEE CHOICE - CHECK ONE

☐ USE ONLY _____ HOURS OF LEAVE.

☐ USE ALL AVAILBLE LEAVE.

☐ DO NOT USE ANY PAID LEAVE.

All information on this form is true and complete to the best of my knowledge. I also have read and understand **CHOICE OF PHYSICIAN** and **PAID LEAVE.**

Signature:_____ Date ___/___/_____

NAME & SIGNATURE OF SUPERVISOR

Name: **Signature:**

TO BE COMPLETED BY DISTRICT ADMINISTRATOR

Date Administrator Notified:___/___/___ Date Submitted to Carrier:___/___/___

Jeanette Revels
Personnel Coordinator
361-694-9216
361-694-9832
jrevels@flourbluffschools.net

EMPLOYEE ACKNOWEDGMENT 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 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: _____

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 www.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.

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS

Important Contact Information
To locate a provider, go to www.pswca.org.
To contact your adjuster at the TASB Risk Management Fund, visit www.tasbrmf.org or call (800) 482-7276.

Information, Instructions, Rights and Obligations

If you are injured at work, tell your supervisor or employer immediately. The information in this notice will help you to seek medical treatment for your injury. Your employer will also help with any questions about how to get treatment. You may also contact your adjuster at the TASB Risk Management Fund (the Fund) for any questions about treatment for a work related injury. The Fund is your employer's workers' compensation coverage provider and they are working with your employer to ensure you receive timely and appropriate health care. The goal is to return you to work as soon as it is safe to do so.

- **How do I choose a treating doctor?**
  If you are hurt at work **and** you live in the Alliance service area, you are required to choose a treating doctor from the provider list. This is required for you to receive coverage of healthcare costs for your work related injury. A provider listing is available through the Alliance website at www.pswca.org and a link to that site is also contained on the Fund's website at www.tasbrmf.org. It identifies providers who are taking new patients.

  If your treating doctor leaves the Alliance, we will tell you in writing. You will have the right to choose another treating doctor from the list of Alliance doctors. If your doctor leaves the Alliance and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra **90 days.**

- **What if I live outside the service area?**
  If you believe you live outside of the service area, you may request a service area review by calling your adjuster.

- **How do I change treating doctors?**
  If you become dissatisfied with your first choice of a treating doctor, you can select an alternate treating doctor from the list of direct contract treating doctors in the service area where you live. The Fund will not deny a choice of an alternate treating doctor. **Before you can change treating doctors a second time, you must obtain permission from your adjuster.**

- **How are treating doctor referrals handled?**
  Referrals for health care services that you or your doctor request will be made available on a timely basis as required by your medical condition. Referrals will be made **no later than 21 days** after the request. Your doctor should refer you to another Alliance provider unless it becomes medically necessary to make a referral outside of the Alliance. You do not have to get a referral if you are in need of emergency care.

- **Who pays for the healthcare?**
  Alliance providers have agreed to seek payment from the Fund for your health care. They should not request payment from you. If you obtain health care from a doctor who is not in the Alliance without prior approval from your adjuster, you may have to pay for the cost of that care and your income benefits may be disputed. You may treat with medical providers that are **not contracted** with the Alliance only if one of the following situations occurs:

  - Emergencies: You should go to the nearest hospital or emergency care facility.
  - You do not live within an Alliance service area.
  - Your treating doctor refers you to a provider or facility outside of the Alliance. This referral must be approved by your adjuster.

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS – PAGE 2

How to File a Complaint

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of direct contract program operations. This includes a complaint about the program and/or your Alliance doctor. It may also be a general complaint about the Alliance. A complainant can notify the Alliance Grievance Coordinator of a complaint by phone, from the Alliance website www.pswca.org or in writing via mail or fax. Complaints should be forwarded to:

PSWCA (The Alliance)
Attention: Grievance Coordinator
P.O. Box 763
Austin, TX 78767-0763
866-997-7922

A complaint must be filed with the program grievance coordinator **no later than 90 days from the date the issue occurred**. Texas law does not permit the Alliance to retaliate against you if you file a complaint against the program. Nor can the Alliance retaliate if you appeal the decision of the program. The law does not permit the Alliance to retaliate against your treating doctor if he or she files a complaint against the program or appeals the decision of the program on your behalf.

What to do when you are injured on the job

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating doctors in your service area may be available from your employer. A complete list of Alliance treating doctors is also available online at www.pswca.org. Or, you may contact us directly at the following address and/or toll-free telephone number:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768
(800) 482-7276

In case of an emergency…

If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility. After you receive emergency care, you may need ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available online at www.pswca.org. If you do not have internet access call (800) 482-7276 or contact your employer for a list. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly with acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

EMPLOYEE NOTICE OF ALLIANCE REQUIREMENTS – PAGE 3

Non-emergency care…
Report your injury to your employer as soon as you can. Select a treating doctor from the Alliance provider list. This list is available online at www.pswca.org. If you do not have internet access, call 800-482-7276 or contact your employer for a list.

Treatments Requiring Advance Approval

Certain treatments or services prescribed by your doctor need to be approved in advance. Your doctor is required to request approval from the TASB Risk Management Fund before the specific treatment or service is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

The following non-emergency healthcare treatment requests must be approved in advance:

Inpatient hospital admissions
Outpatient Surgical or ambulatory surgical services
Spinal Surgery
All non-exempted work hardening
All non-exempted work conditioning
Physical or occupational therapy except for the first six (6) visits if those six visits were done within the first 2 weeks immediately following date of injury or date of surgery
Any investigational or experimental service
All psychological testing and psychotherapy
Repeat diagnostic studies greater than $350.
All durable medical equipment (DME) in excess of $500
Chronic pain management and interdisciplinary pain rehabilitation
Drugs not included in the TDI Division of Workers' Compensation Formulary
All narcotic medications dispensed greater than 60 days
Any treatment or service that exceeds the Official Disability Guidelines.

The number your doctor must call to request one of these treatments is 800-482-7276, ext. 6654. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Concentra

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Patient Name: _____ SSN: _____

Company Name: _____ Date of Birth: _____

Location: _____

Street Address: _____

WORK-RELATED ____ INJURY ____ ILLNESS

Post-Accident Substance Abuse Testing:

_____ Drug Screen
_____ Breath Alcohol
_____ Drug Screen and Breath Alcohol
_____ Urine Collection Only

_____ DOT Regulated
_____ Non-regulated

DOT PHYSICAL

_____ Preplacement
_____ Recertification
_____ Exit
_____ Audiogram
_____ Regulated Drug Screen
_____ Urine Collection Only
_____ Breath Alcohol

PRE-PLACEMENT EVALUATION

Job Title: _____

_____ Physical Exam
_____ HPE
_____ Regulated Drug Screen

_____ Non-regulated Drug Screen
_____ Urine Collection Only
_____ Hair Collection
_____ Audiogram

SPECIAL PHYSICAL EXAMINATIONS

_____ Asbestos
_____ Respirator
_____ Hazmat
_____ Baseline
_____ Other _____

_____

SUBSTANCE ABUSE TESTING

_____ Regulated
_____ Non-regulated
_____ Urine Collection Only
_____ Rapid Test

_____ Pre-placement
_____ Reasonable Suspicion
_____ Random
_____ Periodic
_____ Post-accident
_____ Follow-up

BILLING

_____ Employee to pay charges at time of service
_____ Workers' Compensation
Insurance Co: _____
Policy #: _____
Phone #: _____

Authorized By: _____ Title: _____

Phone: _____ Date: _____

SAMPLE FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET)

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.

_____ _____

District authorized signature Date

Employee choice:

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 or -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 _____ISD 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 Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____