What to do if I get injured at work?

1. All on-the-job injuries/illnesses must be reported to your supervisor immediately – even if you don't think you will need medical treatment or need to be off work.

2. Complete a "Employee First Report of Injury/Illness" form. Have your department head (or designee) sign it.

3. Email/or fax all "Employee First Report of Injury/Illness" forms to safety@irvingisd.net.

Fax #: 469-646-4320

4. If/when you seek medical treatment: Make certain your doctor is aware that you need to be treated under Workers' Compensation when you make your appointment. You may treat with any doctor of your choice – ***however, doctors may choose not to treat patients under Workers' Compensation***.

5. If your doctor will not treat you under Workers' Compensation, you will need to select a doctor who will. Suggested Physicians/Clinics who will treat injuries under W/C are listed on the Risk Management Department website. www.irvingisd.net/riskmanagement

¿Qué hago si me lastimo en el trabajo?

1. Todas las lesiones/enfermedades que suceden en el trabajo deben ser reportadas a su supervisor inmediatamente – aun si usted no piensa necesitar atención medica o faltar al trabajo.

2. Llene un formulario "Employee First Report of Injury/Illness". Obtenga la firma del jefe de departamento (ó persona designada). Mande el original al Departamento de Administración de Riesgos via correo del Distrito.

3. Envie por email o fax todos los formularios "Employee First Report of Injury/Illness" a safety@irvingisd.net.

 # de Fax: 469-646-4320

4. Cuando/si usted busca atención medica: Asegúrese que su doctor este enterado que usted esta necesitando tratamiento bajo Compensación de Trabajadores cuando haga su cita. Usted puede ser tratado por cualquier doctor que usted elija – ***sin embargo, doctores pueden elegir el no tratar a pacientes bajo Compensación de Trabajadores***.

5. Si su doctor no le puede dar tratamiento bajo Compensación de Trabajadores, usted tendrá que seleccionar un doctor que si pueda. Los doctores y clínicas que pueden dar tratamiento bajo Compensación al Trabajador están en la página web del Departamento de Risk Management.

RISK MANAGEMENT DEPARTMENT
IRVING INDEPENDENT SCHOOL DISTRICT

EMPLOYEE FIRST REPORT OF INJURY/ILLNESS

This form is to be completed by the injured employee and the supervisor if assistance is needed. **ALL QUESTIONS MUST BE ANSWERED AND THIS FORM SIGNED BY BOTH THE EMPLOYEE AND THE SUPERVISOR**. Email/fax a copy of this completed form to safety@irvingisd.net / 469-646-4320. Supervisor and employee should retain a copy for their records.

PLEASE PRINT ON ALL LINES, EXCEPT SIGNATURES

1. Name of the injured_____
   (First name) (M.I.) (Last Name) (SS#--Last Four Digits only)
2. Gender: ____ Male ____ Female
3. Date of Birth_____IISD Employee #_____
4. Address_____ TX _____
   (Number, Street, Apt. #) City State Zip Code
5. Telephone number_____
   (Home) (Friend or Relative#)
6. Does employee speak English? ____ Yes ____ No If No, what language? _____
7. Race: ____ White ____ Black ____ Asian
8. Ethnicity: ____ Hispanic ____ Other ____ American Indian
9. Marital Status:____Married____Widowed____Divorced____Separated____Single
10. Number of Dependent Children _____ Spouse's Name _____
11. **Date of Inj/Ill**_____**Day of the Week**_____**Time of Inj/Ill**____:____ ☐ **a.m.** ☐ **p.m.**
12. Job Title of Injured Employee: _____
13. School and location where incident occurred:_____
14. Name of your Principal, Supervisor, or Lead person: _____
15. What date and time they were first notified of your accident? _____ ☐ **a.m.** ☐ **p.m.**
    Date Time
16. Describe below FULLY how the incident occurred and state what the employee was doing when injured or ill. What was the injured employee doing at the time of the accident?

17. Why did the accident occur?

18. Was there any witness(es) to this accident? ____ Yes ____ No

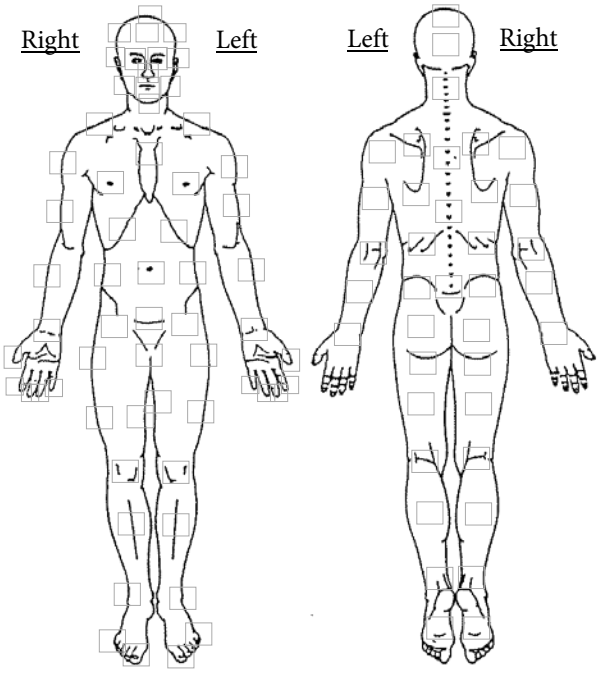
Witness
Name _____ Emp #_____ Phone #_____

19A. Indicate below what act(s) in your opinion contributed to this accident. (Check all that apply.)

- ☐ No wet floor sign posted
- ☐ Not paying attention to surroundings
- ☐ Did not know how to do correctly
- ☐ Did not follow proper procedure
- ☐ Improper placement of objects on shelf
- ☐ Not wearing protective equipment
- ☐ Improper use of body posture
- ☐ Did not use proper equipment (step stool/ladder)
- ☐ Did not follow buddy rule for lifting
- ☐ Overhead reaching
- ☐ Did not use hand rail
- ☐ Emotions were not under control
- ☐ Unsafe area not properly secured
- ☐ Safer act was less convenient
- ☐ Using a cell phone
- ☐ Carrying oversized/unbalanced load
- ☐ Obstructed view
- ☐ Improper pace or speed

19B. If an employee is injured as the result of a physical assault during the performance of their duties, assault leave may be requested. An investigation of the incident will be conducted to confirm or deny assault leave status. Do you wish to file for Assault Leave? ☐ YES ☐ NO ☐ Not Applicable

20. What body part(s) was/were injured?
(Please mark an X on all areas that apply.)



21. What is believed to be the nature of the injury(ies)? (Check all that apply.)

- ☐ Burn
- ☐ Cut
- ☐ Puncture
- ☐ Fracture
- ☐ Contusion (Bruise)
- ☐ Sprain (joint)
- ☐ Strain (muscle)
- ☐ Severance
- ☐ Loss consciousness
- ☐ Dermatitis
- ☐ Electric shock
- ☐ Crushed/pinched
- ☐ Foreign object/liquid

22. Has the injured employee sought medical care for this injury/illness?

☐ Yes ☐ No ☐ Possibly later if needed

23. Name of Doctor or Clinic that you treated or will be treating with under Workers' Compensation:

Name_____

Phone_____

Location_____

(**Employees have the right to the first choice of doctor <u>that will treat under workers compensation</u>. You may change doctors once within 60 days of initial treatment. Notification of your change of doctor to the Texas Department of Insurance (TDI)-Workers' Compensation Division is required. After 60 days of initial treatment, you must obtain approval from TDI in order to change doctors.)

(**Los empleados tienen el derecho de escoger su primer doctor <u>que le dará cuidados bajo compensación al trabajador</u>. Usted puede cambiar de doctor dentro de 60 días después de su primera visita médica. Aviso de su cambio de doctor al Departamento de Seguranza de Texas (TDI)-División de Compensación al Trabajador es requerido. Después de 60 días de su primera visita, usted tendrá que obtener permiso de TDI para cambiar doctores.)

24. The injured/ill employee must choose one of the following options by placing a check in the space provided. ***<u>Failure to choose either option will result in OPTION "A" being chosen by default</u>***. **Changes to the option you select below are only permitted within 7 days from the date this report is completed.**

24. El empleado lesionado/enfermo tiene que escoger una de las siguientes opciones marcando en el espacio dado a la par de la opción deseada. ***<u>El no elegir una de las opciones resultara en que la OPCION "A" sea seleccionada por usted</u>***. Cambios a la opción que usted elija solo serán permitidos dentro de los 7 días de la fecha que este reporte sea llenado.

"In the event that I miss work as a result of a job-related injury or illness, I understand that I will not be eligible for Workers' Compensation weekly income benefits until my absence exceeds seven calendar days. Therefore, I choose the following option(s):"

"En el evento que yo pierda tiempo del trabajo como resultado de una lesión o enfermedad relacionada al trabajo, yo entiendo que no seré elegible para recibir ingresos semanales bajo Compensación al Trabajador hasta que mi ausencia sobre pase 7 días del calendario. Por lo tanto selecciono la siguiente opción(es)."

☐ **Option A:** I choose to use ALL available leave days including vacation, floating holidays, comp time, and EA days. During the first seven calendar days (5 work days plus a weekend) my leave will be used in full-day increments. I understand that once I begin to receive workers' compensation weekly income benefits my leave will be used in partial-day increments to supplement workers' compensation income benefits. At the same time I will use **<u>paid or unpaid</u>** Family and Medical Leave (if I am an eligible employee for FMLA).

☐ Opción A: Yo elijo usar TODO tiempo pagado disponible incluyendo vacaciones, feriados flotantes, tiempo acumulado de horas adicionales, y días ejemplares. Durante los primeros siete días del calendario (5 días de trabajo más un fin de semana) mi ausencia será utilizada en cantidad de días enteros. Yo entiendo que en cuanto yo comience a recibir ingresos semanales bajo compensación al trabajador, mi ausencia será utilizada en cantidad de días parciales para suplementar mis ingresos de compensación al trabajador. Al mismo tiempo yo usare Ausencia Familiar y Médica **<u>con o sin pago</u>** (si es que soy un empleado elegible para FMLA).

☐ **Option B:** I choose **<u>not</u>** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Irving ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balances. I further understand that by selecting this option, I will receive only workers' compensation income benefits for any absences resulting from my work-related illness or injury, **unless I communicate to the District a change in my position within the allotted 7 days from the date this report was completed.** At the same time I will use **<u>unpaid</u>** Family and Medical Leave (if I am an eligible employee for FMLA).

☐ Opción B: Yo elijo **<u>no</u>** usar ningún tiempo pagado disponible en este momento. Yo entiendo que no voy a recibir pagos regulares de salario de Irving ISD mientras que esté recibiendo ingresos semanales bajo compensación al trabajador. Ningún tiempo será tomado de mis horas acumuladas. Aun más, entiendo que al escoger esta opción, yo solo recibiré beneficios de ingresos de compensación al trabajador por cualquier ausencias que sean resultado de una lesión o enfermedad relacionada al trabajo, al menos que yo le comunique al Distrito dentro de los 7 días permitidos de la fecha que este reporte sea llenado. Al mismo tiempo yo usare Ausencia Familiar y Médica sin pago (si es que soy un empleado elegible para FMLA).

_____ _____
(Signature of Employee) (Date)

_____ _____
(Signature of Supervisor) (Date)

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: Irving Independent School District
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.

TASB RISK FUND