Employee statement regarding injury/illness/incident

Instructions: This form is for the collection and reporting of data associated with a reported work-related injury, illness, or incident. Supervisors should have employees reporting a work-related injury, illness, or incident immediately complete this form. This completed document along with all other required injury, illness, or incident forms should be sent to the Business Office within 24 hours of receiving notice of the injury, illness, or incident.

First name:	Middle initial:	Last name:

Home Address:	Sex:	# of dependents:
	Marital Status:	Year hired:

Soc Sec #:	Date of Birth:	Home phone:	Date of incident:	Time of incident: ☐ am ☐ pm

Last work date:	Date employer notified:	Occupation/Job Title:	Time began work: ☐ am ☐ pm

Date returned to work:	Any lost time? (if so, fill out election form, page 2)	Medical Treatment Received? (if so, provide info next)	Where did the incident occur?

Physician/Health Care Provider (Name & Address):	Hospital (Name & Address):

What were you doing when the incident occurred? *(Please indicate task being performed and include the activities immediately before incident)*

Give a detailed description of how the injury/illness occurred. *(Please include details about the work environment and any items being used)*

Describe the injury/illness and body part(s) affected. *(Please be specific, for example: I burned the tip of my index finger on the right hand.)*

Who was present when the injury/illness occurred? *(Please include the full names of anyone present)*

What changes do you suggest to prevent this from happening again?

Employee Signature:	Date:

ELECTION TO USE PAID LEAVE

Name:	Employee ID #:
First date absent from duty due to job related injury/illness:	

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.

_____ _____

Principal/Supervisor signature Date

Employee choice:

If eligible, Temporary Income Benefits will pay you up to 70% of your average weekly wages to a maximum of $712 weekly beginning on the eighth calendar day of your absence due to a work related injury/illness. The period between the first day of your absence and the eighth calendar day is not paid by the District – this form allows you to elect to use your paid leave for the seven day waiting period and/or until you return to work from a work related injury/illness absence.

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 choose the following option for the waiting period and/or any subsequent lost time after the 8th day of my absence: (*Please check one*)

☐ I choose to use all of my available paid leave in order to receive 100% of my pay from the District throughout my absence. Once my paid leave balance is exhausted, I choose to be paid Workers' Compensation Temporary Income Benefits (TIBs) if necessary. 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 to use only _____ number of days of my available paid leave at this time. After these days are used, I choose to be paid Workers' Compensation Temporary Income Benefits (TIBs) if necessary.

☐ I choose **not** to use any of my available paid leave at this time. I understand that I will not receive any regular salary payments from Iraan-Sheffield 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.

This form must be filed with the employee's Report of Injury form as well as their Absence From Duty form.

_____ _____

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: _____

EMPLOYEE ACKNOWLEDGMENT 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: IRAAN-SHEFFIELD ISD

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.