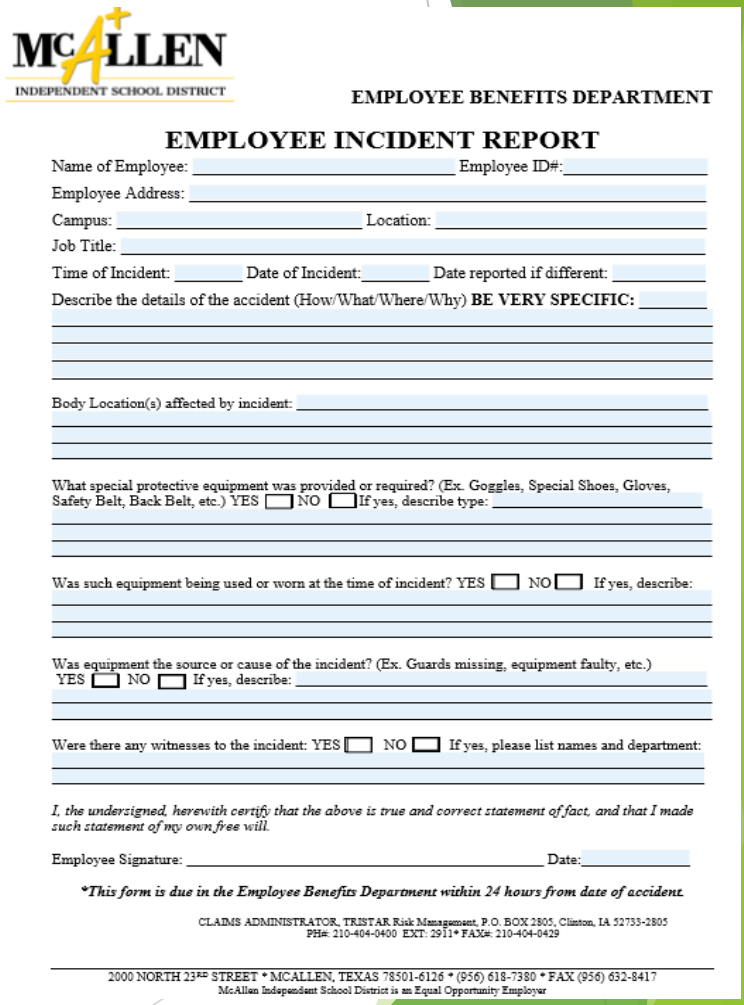
Employee Benefits Workers' Compensation

- Self Funded Plan
- Its sole purpose is for Medical Benefits & Loss Time Wages due to work related injury/illness.

- Overview:
  - Employees Role
  - Supervisors Role
  - Witnesses Role
  - Restrictions

Employee Benefits Workers' Compensation

- **EMPLOYEE-What to do in the event of a work-related illness or injury**:
  - Notify Supervisor immediately
  - Fill out a Workers' Compensation Forms
    - 1. Complete the Employee Incident Report
    - Forms are available online (MISD Benefits webpage)
    - If medical treatment is required, report to the Employee Benefits Office for Authorization Form to seek treatment.
      - Exception- Emergency situations requiring immediate medical attention. Employee may seek treatment directly but contact the Employee Benefits Office by phone immediately with details of the incident.



McALLEN INDEPENDENT SCHOOL DISTRICT

EMPLOYEE BENEFITS DEPARTMENT

EMPLOYEE INCIDENT REPORT

Name of Employee: _____ Employee ID#: _____

Employee Address: _____

Campus: _____ Location: _____

Job Title: _____

Time of Incident: _____ Date of Incident: _____ Date reported if different: _____

Describe the details of the accident (How/What/Where/Why) **BE VERY SPECIFIC:** _____

Body Location(s) affected by incident: _____

What special protective equipment was provided or required? (Ex. Goggles, Special Shoes, Gloves, Safety Belt, Back Belt, etc.) YES ☐ NO ☐ If yes, describe type: _____

Was such equipment being used or worn at the time of incident? YES ☐ NO ☐ If yes, describe:

Was equipment the source or cause of the incident? (Ex. Guards missing, equipment faulty, etc.) YES ☐ NO ☐ If yes, describe: _____

Were there any witnesses to the incident: YES ☐ NO ☐ If yes, please list names and department:

I, the undersigned, herewith certify that the above is true and correct statement of fact, and that I made such statement of my own free will.

Employee Signature: _____ Date: _____

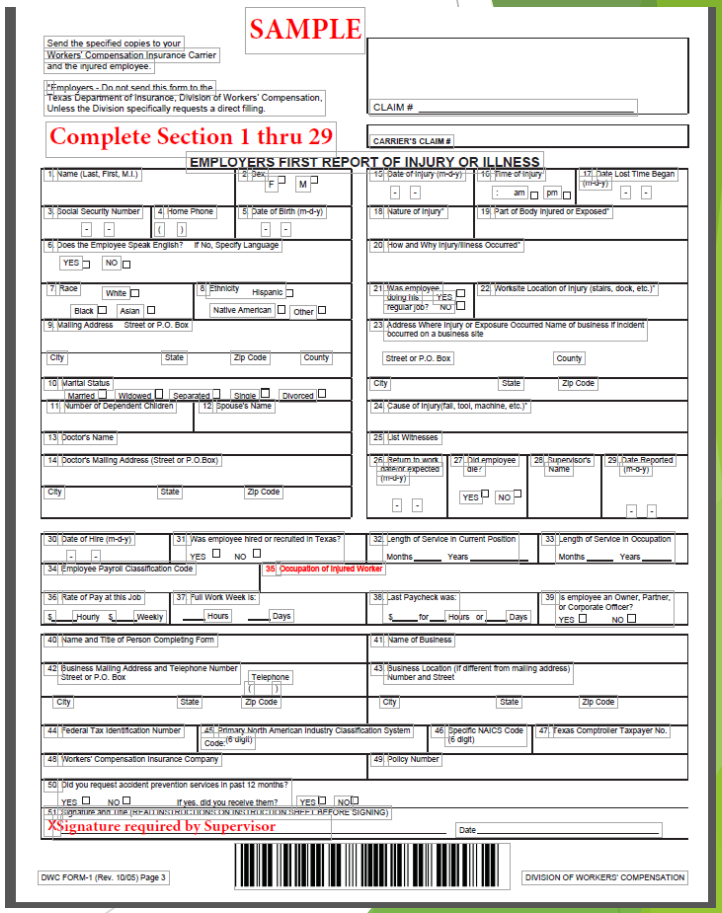
This form is due in the Employee Benefits Department within 24 hours from date of accident.

CLAIMS ADMINISTRATOR, TRISTAR Risk Management, P.O. BOX 2805, Clinton, IA 52733-2805
PH#: 210-404-0400 EXT: 2911* FAX#: 210-404-0429

2000 NORTH 23RD STREET * MCALLEN, TEXAS 78501-6126 * (956) 618-7380 * FAX (956) 632-8417
McAllen Independent School District is an Equal Opportunity Employer

Employee Benefits
Workers' Compensation

- DEPARTMENT SUPERVISORS
  - Fill out the First Report of Injury (DWC1) (Employer/Department Information, Signature is required)
    - Complete section 1 thru 29 and Section 51
    - Forward copies of Forms to Employee Benefits Office
    - Form can be given to the employee to turn in along with the First Incident Report.


SAMPLE

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

Complete Section 1 thru 29

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1 Name (Last, First, M.I.) | 2 Sex F M | 15 Date of Injury (m-d-y) | 16 Time of Injury am pm | 17 Date Last Time Began (m-d-y)

3 Social Security Number | 4 Home Phone | 5 Date of Birth (m-d-y) | 18 Nature of Injury* | 19 Part of Body Injured or Exposed*

6 Does the Employee Speak English? If No, Specify Language YES NO | 20 How and Why Injury/Illness Occurred*

7 Race White Black Asian | 8 Ethnicity Hispanic Native American Other | 21 Was employee doing his / her regular job? YES NO | 22 Worksite Location of Injury (stairs, dock, etc.)*

9 Mailing Address Street or P.O. Box | City State Zip Code County | 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

10 Marital Status Married Widowed Separated Single Divorced

11 Number of Dependent Children | 12 Spouse's Name | 24 Cause of Injury(fall, tool, machine, etc.)*

13 Doctor's Name | 25 List Witnesses

14 Doctor's Mailing Address (Street or P.O.Box) | City State Zip Code | 26 Return to work date(s) expected (m-d-y) | 27 Did employee die? YES NO | 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 NO | 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 NO

40 Name and Title of Person Completing Form | 41 Name of Business

42 Business Mailing Address and Telephone Number Street or P.O. Box Telephone | City State Zip Code | 43 Business Location (if different from mailing address) Number and Street | City State Zip Code

44 Federal Tax Identification Number | 45 Primary North American Industry Classification System Code (6 digit) | 46 Specific NAICS Code (6 digit) | 47 Texas Comptroller Taxpayer No.

48 Workers' Compensation Insurance Company | 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)

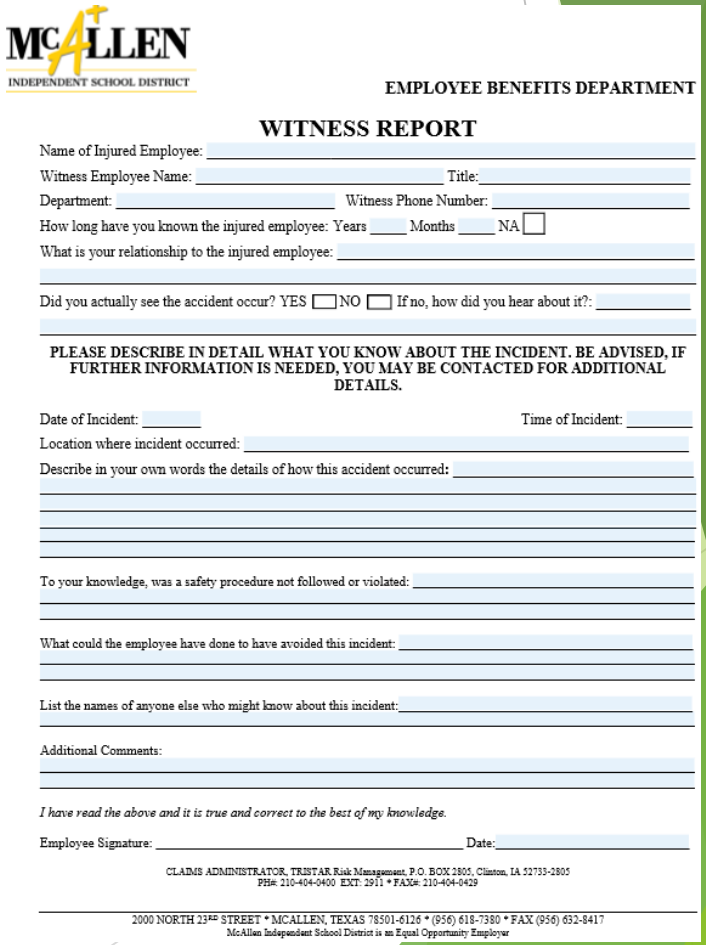
XSignature required by Supervisor | Date

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

Employee Benefits
Workers' Compensation

- WITNESSES
  - Complete the Witness Report
  - Forward the Witness Report to Employee Benefits Office
  - All forms are available in Spanish as well.



McALLEN INDEPENDENT SCHOOL DISTRICT

EMPLOYEE BENEFITS DEPARTMENT

WITNESS REPORT

Name of Injured Employee: _____

Witness Employee Name: _____ Title: _____

Department: _____ Witness Phone Number: _____

How long have you known the injured employee: Years ____ Months ____ NA ☐

What is your relationship to the injured employee: _____

Did you actually see the accident occur? YES ☐ NO ☐ If no, how did you hear about it?: _____

PLEASE DESCRIBE IN DETAIL WHAT YOU KNOW ABOUT THE INCIDENT. BE ADVISED, IF FURTHER INFORMATION IS NEEDED, YOU MAY BE CONTACTED FOR ADDITIONAL DETAILS.

Date of Incident: _____ Time of Incident: _____

Location where incident occurred: _____

Describe in your own words the details of how this accident occurred: _____

To your knowledge, was a safety procedure not followed or violated: _____

What could the employee have done to have avoided this incident: _____

List the names of anyone else who might know about this incident: _____

Additional Comments: _____

I have read the above and it is true and correct to the best of my knowledge.

Employee Signature: _____ Date: _____

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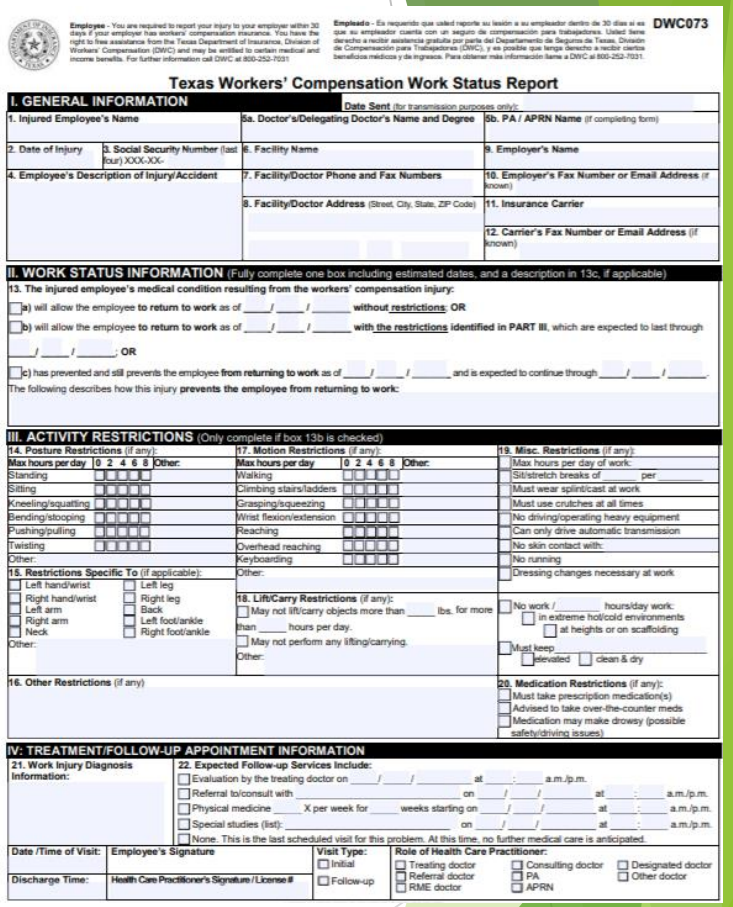
Employee Benefits Workers' Compensation

- Before Returning to Work:
  - Provide the Work Status Report Form
    (Given to you by the doctor)
  - Doctor's release with restriction:
    - Light Duty – May or May NOT be approved depending on the job position.
    - Must be approved by immediate supervisor if not released to full duty and submitted to Employee Benefits prior to returning



Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation (DWC) and may be entitled to certain medical and income benefits. For further information call DWC at 800-252-7031.

Empleado - Es requerido que usted reporte su lesión a su empleador dentro de 30 días si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte del Departamento de Seguros de Texas, División de Compensación para Trabajadores (DWC), y es posible que tenga derecho a recibir ciertos beneficios médicos y de ingreso. Para obtener más información llame a DWC al 800-252-7031.

DWC073

Texas Workers' Compensation Work Status Report

I. GENERAL INFORMATION — Date Sent (for transmission purposes only):

1. Injured Employee's Name
2. Date of Injury
3. Social Security Number (last four) XXX-XX-
4. Employee's Description of Injury/Accident
5a. Doctor's/Delegating Doctor's Name and Degree
5b. PA / APRN Name (if completing form)
6. Facility Name
7. Facility/Doctor Phone and Fax Numbers
8. Facility/Doctor Address (Street, City, State, ZIP Code)
9. Employer's Name
10. Employer's Fax Number or Email Address (if known)
11. Insurance Carrier
12. Carrier's Fax Number or Email Address (if known)

II. WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if applicable)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ a) will allow the employee **to return to work** as of ____/____/____ **without restrictions; OR**

☐ b) will allow the employee **to return to work** as of ____/____/____ **with the restrictions identified in PART III**, which are expected to last through ____/____/____; **OR**

☐ c) has prevented and still prevents the employee **from returning to work** as of ____/____/____, and is expected to continue through ____/____/____.

The following describes how this injury **prevents the employee from returning to work:**

III. ACTIVITY RESTRICTIONS (Only complete if box 13b is checked)

14. Posture Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/squatting	☐	☐	☐	☐	☐	
Bending/stooping	☐	☐	☐	☐	☐	
Pushing/pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:						

15. Restrictions Specific To (if applicable):
☐ Left hand/wrist ☐ Left leg
☐ Right hand/wrist ☐ Right leg
☐ Left arm ☐ Back
☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ Right foot/ankle
Other:

16. Other Restrictions (if any)

17. Motion Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladders	☐	☐	☐	☐	☐	
Grasping/squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	

Other:

18. Lift/Carry Restrictions (if any):
☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day.
☐ May not perform any lifting/carrying.
Other:

19. Misc. Restrictions (if any):
☐ Max hours per day of work: ____
☐ Sit/stretch breaks of ____ per ____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No skin contact with:
☐ No running
☐ Dressing changes necessary at work
☐ No work / ____ hours/day work.
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep ____
☐ elevated ☐ clean & dry

20. Medication Restrictions (if any):
☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:
☐ Evaluation by the treating doctor on ____/____/____ at ____:____ a.m./p.m.
☐ Referral to/consult with ____ on ____/____/____ at ____:____ a.m./p.m.
☐ Physical medicine ____ X per week for ____ weeks starting on ____/____/____ at ____:____ a.m./p.m.
☐ Special studies (list): ____ on ____/____/____ at ____:____ a.m./p.m.
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date /Time of Visit:
Employee's Signature
Visit Type: ☐ Initial ☐ Follow-up
Role of Health Care Practitioner: ☐ Treating doctor ☐ Consulting doctor ☐ Designated doctor ☐ Referral doctor ☐ PA ☐ Other doctor ☐ RME doctor ☐ APRN
Discharge Time:
Health Care Practitioner's Signature / License #

Employee Benefits
Workers' Compensation

CONTACT:

Ms. Elvira Solis, Employee Benefits Clerk at 632-8430 or email at benefits@mcallenisd.net