

Instructions

Employee's Report of Injury

Purpose of Form:

The injured employee completes this form to provide the State Office of Risk Management (SORM) with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury in order to help expedite benefits.

Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the *First Report of Injury or Illness Form* (DWC-1S) is reported by the agency.

Completed by:

This form shall be completed by the injured employee with assistance from the Claims Coordinator, if needed.

Instructions:

1. The employee will address each of the questions completely and use additional pages if necessary. The adjuster needs a complete picture of the events surrounding the injury and how the injury occurred. Witnesses' names and phone numbers, physicians/treatment provider's names and phone numbers and work status is needed. The employee should enter any previous workers compensation claims information including body parts injured.
2. The injured employee will sign and date the form thereby attesting that all information on the form is true and complete.

Distribution

The Claims Coordinator shall retain the original for the agency file and fax or mail a copy to:

State Office of Risk Management
P.O. Box 13777
Austin, TX 78711
Fax: (512) 370-9025

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.

INSTRUCTIONS

Employee's Election Regarding Utilization of Sick and Annual Leave

Injured employees may elect to use accrued sick leave and all, part, or none of their accrued annual leave for time missed from work due to the work-related injury. Accrued sick leave and accrued annual leave are the amounts of paid leave available at the time of injury in addition to leave earned after the injury. The following details the effects of the different choices available to you.

If You Choose Election 1

- You must use all accrued sick leave but may elect to use all, some, or none of your accrued annual leave.
- All sick leave must be exhausted before annual leave may be used.
- If you select 1A and return to work but later have additional days of disability, you must use any accrued sick and annual leave before receiving workers' compensation income benefits.
- If you select 1B, you must use any sick leave balance and any authorized annual leave before you will be eligible to receive workers' compensation income benefits.
- If you select 1C, you must use any/all accrued sick leave before receiving workers' compensation income benefits.
- Workers' compensation income benefits do not begin until the eighth day of disability. Employees who are disabled for at least 14 days will receive retroactive benefits for any portion of the seven-day waiting period not paid by leave.
- You will continue to receive your full pay as long as you have accrued time to use and have authorized your agency to use it for your injury. If your elected leave is exhausted, you may receive income benefits to replace a portion of your lost wages. This may be 70% or 75% of your average weekly wage depending on your wages at the time of your injury.
- It is recommended that you consult with your Human Resources Department to discuss the impact of your selection on your leave balances and insurance benefits should you be off work for an extended period of time.

If You Choose Election 2

- You choose to not use any sick or annual leave for your compensable injury. Your agency may immediately place you in a leave without pay status.
- You may not receive any workers' compensation income benefits for the first seven (7) calendar days you are unable to work. If eligible, your income replacement benefits will begin on the 8th day of disability and employees who are unable to work for 14 days will receive retroactive benefits for the first seven days. You will be paid at a rate of 70 or 75% of your weekly wage depending on your wages at the time of your injury.

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Instructions Witness Statement

Required:

Immediately after receiving notice of any injury, the Claims Coordinator should determine the names, addresses, and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to SORM.

Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the first notice of injury is reported to the agency.

Completed by:

This form should be completed by the person giving the statement with assistance from the Claims Coordinator.

Instructions:

1. Be as specific and complete as possible.
2. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
3. Please provide the SORM claim number, if known.
4. The witness may have actually seen the incident or may have acquired knowledge about the accident from another source. The witness information may relate to how the incident occurred or to something else that is relevant. Sometimes you will be given a witness name but, when asked, the witness may deny any knowledge of the incident. In such a case the third box should be checked.
5. If the space provided on the form is insufficient please attach additional information.

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Instructions Authorization for Release of Information

Required:

This document is required immediately after sustaining a work-related injury. The injured employee should complete this release form. This enables SORM to obtain copies of relevant medical documents from healthcare provider that will assist in the handling of the claim.

Filing Deadline:

The form must be received by SORM no later than the 5th calendar day after the First Report of Injury or Illness (DWC-1S) to the claimant's employer.

Completed by:

The employee must complete this form. If the employee is incapacitated, the spouse, child, or legal guardian may sign the form. **THIS FORM MUST BE SIGNED AND DATED.** The Claims Coordinator should make this form available for all injuries.

Instructions:

1. The injured employee must clearly print his or her name on the patient line.
2. The injured employee must clearly print his or her name on the second line.
3. The injured employee must sign and date the form.

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