## EMPLOYEE WORKERS COMPENSATION RESPONSIBILITES

**If you are an employee who has been injured on the job, follow the steps below:**

1. If this is an emergency call 911 or report to an ER with the supervisor to validate/approve care
    a. If this is not an emergency, seek medical treatment at one of the approved facilities within the CareWorks Network (www.careworks.com)
2. Report the incident/injury to your supervisor.
3. Complete the Employee Injury Packet and attach to the online incident report.
4. Complete the online Incident Form in Origami using this link - https://live.origamirisk.com/Origami/IncidentEntry/Welcome
5. Communicate with the Supervisor and Risk Management (RM) coordinator about ongoing/follow-up treatment.
6. RM claims coordinator will contact you as necessary or until you have returned to full duty.
7. The RM claims coordinator will submit the claim to the State on your behalf.
    a. Once the claim is submitted to the State Office of Risk Management (SORM), the state adjuster contacts you as necessary.

**FORMS INCLUDED IN THIS PACKET**

1. Employee's Report of Injury
2. Employee's Election Regarding Utilization of Sick and Annual Leave
3. Witness Statement
4. Authorization for Release of Information
5. Workers Compensation Network Acknowledgement

**INSTRUCTIONS**

There are instructions for completing the required forms under the Related Forms section of the Risk Management website.

**Questions**

Please contact the claims coordinator at 806.742.0212 or by email ttus.workerscomp@ttu.edu

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# EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____
Last First M.I. Maiden

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Email address:

Social Security: _____ Gender: ☐M ☐F

Date of Injury: _____

Employer: _____

Job Title: _____

Work Schedule: _____

1) What was the exact location of the accident? Include street address if possible:

2) What was happening at the time? What was going on around you, what were you doing, what were other people doing?:

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date: _____ Time: _____

Name: _____ Title: _____ Phone Number: _____

6) List all known witnesses (continue on back if necessary): 1. Name: _____ Phone: _____

2. Name: _____ Phone: _____ 3. Name: _____ Phone:_____

7) Who is your Primary Care Physician or family doctor? Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

9) Has a doctor taken you off work? ☐Yes ☐No If Yes, when was the first day you missed work?_____

10) If the doctor took you off of work, have you returned to work? ☐Yes ☐No If No, when do you think you will return to work? _____

11) Date of Last Appointment: _____ Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ☐Yes ☐No If Yes, please enter injury dates and body parts injured:

*By affixing my signature, I attest that all information on this form is accurate and true:*

Signature: _____ Date: _____

State Office of Risk Management

# EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE

Employee's Name: _____ Date of Injury: _____

Employee's SSN: _____ Agency Name: _____

**You are not required to use your leave.** Texas Labor Code §501.044 allows an injured state employee to elect to use accrued sick and annual leave before receiving income benefits. NOTE: Sick leave must be exhausted before annual leave may be used. Other categories of leave (compensatory leave, holiday leave, administrative leave, etc.) may not be used prior to sick and annual leave.

## Select only ONE election, either Election 1 or Election 2 below:

### ☐ ELECTION 1—Choose A, B, or C

When I lose time from work due to this injury or illness, I elect to use all of my accrued sick leave **AND**:

☐ A. All of my accrued annual leave.

☐ B. A portion of my accrued annual leave (enter number below).

☐ C. None of my accrued annual leave.

If you selected B, how much of the portion of your leave do you wish to donate?

### ☐ ELECTION 2

When I lose time from work due to this injury or illness, I elect to not use any accrued sick leave or annual leave. I understand I am not entitled to workers' compensation income benefits until after the seven (7) calendar day waiting period.

If you know, please indicate how hours you have available: _____ Sick Hours: _____ Annual Hours: _____

## MONTHLY TEMPORARY INCOME BENEFITS (TIB) ELECTION

☐ I elect to change my Temporary Income Benefits frequency from weekly to monthly. For more information about TIB, please visit the Texas Dept. of Insurance website (https://www.tdi.texas.gov/wc/employee/tempben.html).

By signing below, I signify that I understand that I may not change my election after my eighth (8th) day of disability and that I have read the instructions on page 2.

| Employee's Signature | Date | Coordinator's Signature | Date |
|---|---|---|---|



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# WITNESS STATEMENT

***MUST BE TYPED OR PRINTED***

Injured Employee Name: _____ Date of Injury: _____

SORM Claim Number: _____ Statement Taken By: _____

Witness Name: _____

Witness Email Address: _____

Residence Address: _____

Primary Telephone: _____ Secondary Telephone: _____

Witness Employer: _____

On _____ (date), at about _____ (time) in the ☐ a.m. / ☐ p.m., I was in or at _____ when an accident involving the above employee is reported to have occurred.

**SELECT CHOICE A, B, OR C BELOW:**

Check only *one* box:

A. ☐ I saw the incident. The accident occurred in the following manner:

Other pertinent information and source:

B. ☐ I did not see the incident. Information given to me by (name of person):

Indicate how it occurred:

Other pertinent information and source:

C. ☐ I know nothing whatsoever about the incident.

_____ _____

Signature Date


# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:_____

**TO WHOM IT MAY CONCERN:**

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X- ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information, but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name)_____

SIGNED:_____ DATED:_____

*Copies of this signed authorization will be considered just as valid as the original. This is not a release of claims for damages.*

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

State Office of Risk Management
PO Box 13777
Austin, TX 78711-3777
(512) 475-1440
Fax: (512) 370-9025

**CareWorks Managed Care Services**
10535 Boyer Blvd., Ste 100
Austin, TX 78758

P: 800.580.1314
F: 800.580.3123
E: Compkey@careworksmcs.com

CareWorks

# Workers Compensation Network Acknowledgement

I have received information that tells me how to get health care under workers' compensation insurance.

**If I am hurt on the job and live in the service area described in this information, I understand that:**

1. I must choose a treating doctor from the list of doctors in the network.
2. I may ask my HMO primary care physician to agree to serve as my treating doctor.
3. 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 anywhere.
4. The insurance carrier will pay the treating doctor and other network providers.
5. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

**Signature** **Date**

**Printed name**

**Street Address**

**City** **State** **Zip code** **County**

**Name of employer**

CAREWORKS HCN

**Name of network**