SUPERVISOR WORKERS COMPENSATION RESPONSIBILITES

If you are the supervisor of an employee who is injured, follow the steps below:

1. If this is an emergency call 911 or report to an ER with the employee to validate/approve care
    a. If this is not an emergency, assist the employee in medical treatment at one of the approved facilities within the CareWorks Network (www.careworks.com)
2. If the employee has not submitted the incident/injury into Origami, submit the report on their behalf using this link - https://live.origamirisk.com/Origami/IncidentEntry/Welcome
3. Complete the Supervisor's Workers' Compensation (WC) packet contained in this document.
    a. Once completed please email to ttus.workerscomp@ttu.edu
4. Communicate with the employee and the Risk Management (RM) coordinator until the employee has returned to full duty.
5. The RM claims coordinator will contact the supervisor/employee as necessary or until the employee has returned to full duty.
6. Communicate to the RM claims coordinator if the employee has lost time, an altered work schedule or job function due to injury via the Bona Fide Job Offer (BFJO) document.
    a. The Bona Fide Job Offer is part of the Supervisor's Workers' Compensation packet.
7. Once the claim is submitted to the SORM, the state adjuster will contact the employee as necessary.

FORMS INCLUDED IN THIS PACKET

1. Supervisor's Investigation of Employee's Accident/Incident
2. Bona Fide Offer of Employment

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

State Office of Risk Management
Incident/Accident Investigation Form 703

A. Employee Data				Claim # (if known):			
Date of incident:				Time:		☐ A.M	☐ P.M.
Employee Name:							
Working Title:				Dept.			
Employee Contact #:	Hm.		Wk.		Other		
Supervisor Contact:					Wk		

B. Incident Description

Obtain written and/or recorded statements from injured employee. What happened? What caused the accident? What were the contributing factors? Reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. This document becomes a legal accounting of the facts surrounding the incident/accident. When documenting the facts, include answers to the following questions:

1. Where did the incident happen? Provide a full description of the surroundings of the location.
2. What was happening at the time of the incident? What were the events leading up to the incident?
3. What exactly caused the physical injury? What were the mechanics involved? Or, if a physical injury was avoided, what could have happened to cause an injury?
4. Describe any injury incurred by the employee, what body part/s and what kind/s of injury/ies. If there are no injuries, so state.

C. Incident Findings
After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/ injury?
D. Corrective Action
What is recommended to prevent this type of incident/accident from occurring again?
Actions taken to ensure recommendations are considered:
Signature of Accident Investigator **Date** **Time**

Internal Distribution:

Original: Agency Risk Manager or Risk Management Contact

Copies: Agency Safety Officer
Employee's Supervisor
Director/Manager of Department or Section

Maintain one copy in any retrievable format in the site file for a minimum of 3 years, or in the case of an occupational illness or injury, for 30 years.

Note: If a workers' compensation claim is filed, send:

- **Fax a copy to the State Office of Risk Management (SORM) Claims Department at 512-472-0237.**

BONA FIDE OFFER OF EMPLOYMENT

Re: Bona Fide Offer of Employment

Dear:

After reviewing the information provided by your doctor, we are offering you the following temporary work assignment.

This assignment is within your capabilities as described by your doctor on the attached Work Status Report (DWC-73). You will only be assigned tasks consistent with your physical abilities, skills and knowledge. If any training is required to do this assignment, it will be provided.

Position title: _____

Description of physical requirements of this position: _____

_____

Location: _____

Duration of assignment: From: (_____) To: (_____)

Work Hours: From: (_____) To: (_____)

Wages: _____(Hour, Week, Month)

Department: _____ Supervisor: _____

This job offer will remain open for seven (7) calendar days from your receipt of this letter. If you do not respond within seven (7) calendar days, we will presume you have refused this offer. Refusing this offer may impact your income benefits.

We look forward to your return. If you have any questions, please do not hesitate to contact me **(include phone number or email address).**

Sincerely,

_____ _____ _____

Signature **Printed Name** **Date**

EMPLOYEE:

☐ I have read and understand the requirements of the position and accept the position.

☐ I have read and understand the requirements of the position but do NOT accept the position.

_____ _____

Employee's Signature **Date Signed**