DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

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.**

[Workers' Compensation Rule 120.2]

FISD Workers Compensation Specialist
Email or Fax to: Dafne Rodriguez
Email: workerscomp@friscoisd.org
Phone: 469-633-6346
Fax: 469-633-6325

FISD WC Administrator
Janet Leonardo
Email: leonardoj@friscoisd.org

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. 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.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. 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.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

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 filling.

Email or Fax to: Dafne Rodriguez
Email: workerscomp@friscoisd.org
Phone: Dafne 469-633-6346
Fax: 469-633-6325
CLAIM # _____

Employee ID#:

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security Number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
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
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
26. Return to work date/or 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 **8868 Professional**
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 Monthly
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
Janet Leonardo - FISD RISK MGMT/WORKERS COMPENSATION
41. Name of Business
FRISCO ISD
42. Business Mailing Address and Telephone Number
Street or P.O. Box **5515 OHIO DRIVE**
Telephone **(469) 633-6345**
City **FRISCO** State **TX** Zip Code **75035**
43. Business Location (If different from mailing address)
Number and Street **5515 OHIO DRIVE**
City **FRISCO** State **TX** Zip Code **75035**
44. Federal Tax Identification Number **75-6001636**
45. Primary North American Industry Classification System Code:(6 digit) **611110**
46. Specific NAICS Code (6 digit) **611110**
47. Texas Comptroller Taxpayer No. **75-6001636**
48. Workers' Compensation Insurance Company
CLAIMS ADMINISTRATIVE SERVICES
49. Policy Number
SELF-INSURED
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)
X _____ Date _____

Frisco ISD: **Dafne**
Email: **workerscomp@friscoisd.org**
Phone: Dafne 469-633-6346 **Fax:** **469-633-6325**

Claims Administrative Services, Inc.

Our reputation for excellence is no accident.® / Nuestro prestigio por buscar la excelencia no es accidente

Employee's Injury Report / Informe de lesión de empleado

This form must be completed in detail and signed by the injured employee. / El empleado lesionado debe llenar detalladamente y por completo este formulario, y firmarlo.

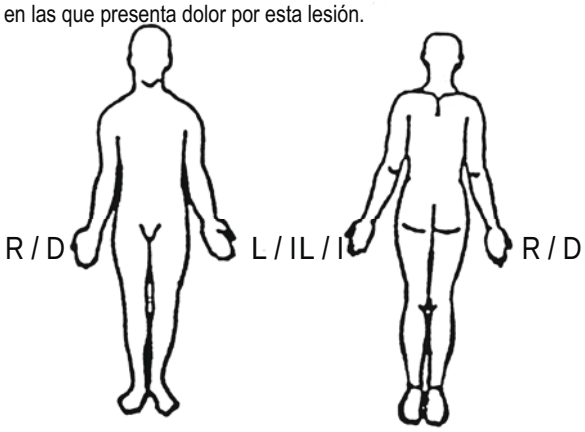
Your Full Name / Nombre completo		Department You Work For / Departamento en el que labora
Social Security Number (Last 4 digits only) / No. de seguro social (últimos 4 dígitos) XXXX-XX-	Date of Birth / Fecha de nacimiento	Location of Accident / Lugar del accidente
Your Address (Street, City, State, County, Zip) / Domicilio (Calle, Ciudad, Estado, Condado, C.P.)		Supervisor's Name / Nombre de supervisor
Phone Number Where You Can be Reached / Teléfono donde se le puede localizar		Job Title at Time of Injury / Puesto de trabajo cuando ocurrió la lesión
Date of Hire / Fecha de contratación		How Long in Current Position / Antigüedad en puesto actual Yrs. / Años Mos. / Meses

Details of the Injury / Detalles de la lesión

Date of Injury / Fecha de la lesión	Time of Injury / Hora de la lesión AM / PM	Date you first Lost Time / Fecha de inicio de la incapacidad
Where in the workplace did your injury occur? / ¿En qué parte de su trabajo ocurrió la lesión?		
Describe in detail how your injury occurred. / Describa detalladamente cómo ocurrió su lesión.		
What safety equipment were you using at the time of the accident? / ¿Qué equipo de seguridad usaba cuando ocurrió el incidente?		
What can be done to prevent this type of injury in the future? / ¿Qué se puede hacer para evitar este tipo de lesión en el futuro?		

When were you first aware of this injury? / ¿Cuándo identificó la lesión por primera vez?	
When did you first notify your supervisor of your injury? / ¿Cuándo informó por primera vez de la lesión a su supervisor?	
What part of your body is injured? / ¿Qué parte de su cuerpo se lesionó?	Describe the injury. / Describa la lesión.

On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury. / En el diagrama a continuación, por favor marque con un círculo la parte o partes de su cuerpo en las que presenta dolor por esta lesión.



Did anyone witness your accident? List the names of any witnesses. / ¿Alguien presenció el incidente? Escriba los nombres de los testigos.

Was anyone else injured in this accident? List the names of any other injured people. / ¿Alguien más resultó lesionado en este incidente? Escriba los nombres de cualquier otro lesionado.

In the incident that caused your injury, was there damage to any property or equipment? Describe any damage. / En el incidente que ocasionó su lesión, ¿hubo daños a la propiedad o a los equipos? Describa los daños.

I certify that the information contained in this report is true and correct. / Declaro que la información aquí presentada es correcta y verdadera.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes. / Comprendo que la falsificación de información con respecto a una lesión laboral puede castigarse con alguna medida disciplinaria o demanda judicial de acuerdo con las Leyes Penales Estatales.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company. / Por medio del presente formulario, autorizo que los registros médicos relacionados con el incidente aquí descrito sean compartidos con mi empleador, su agente o compañía de seguros.

Employee's Printed Name / Nombre completo del empleado	Employee's Signature / Firma del empleado	Date / Fecha

I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date. / Doy fe de que el empleado cuyos datos aquí se han asentado me ha indicado que comprendió todas las preguntas y que firmó y fechó este formulario en mi presencia en este día.

Witness' Printed Name / Nombre completo del testigo	Witness' Signature / Firma del testigo	Date / Fecha

FRISCO
INDEPENDENT SCHOOL DISTRICT

HIPAA Authorization for Disclosure of Protected Health Information

I, _____, date of birth _____, Social Security No. _____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

   All healthcare providers who have provided healthcare to me.

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

   Name: *Claims Administrative Services, Inc.*
   P.O. Box 7500
   Tyler, Texas 75711

   Texas Dept. of Insurance – Division of Workers' Compensation
   7551 Metro Center Drive, Suite 100
   Austin, Texas 78744-1609

   Others: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

   I further specifically authorize the disclosure of psychotherapy notes, if any.
4. The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

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[1] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

[2] These laws apply to health plans, health care providers, and health care clearinghouses.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.

7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.

8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.

9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

_____ _____

Signed Date

Name: _____

Address: _____

Telephone: _____ SSN: _____

DOB: _____

FRISCO ISD WORKERS' COMPENSATION PROGRAM

EMPLOYEE

INFORMATION SHEET

General Information

The Frisco Independent School District (Frisco ISD) provides workers' compensation benefits to employees who are injured at work. This benefit will cover only a work-related injury or illness, not other medical problems. Once a claim is reported and accepted by the Frisco ISD workers' compensation program as compensable (eligible), your workers' compensation benefits begin. This is the only medical benefit you may use for treatment of your specific claim/injury, including medical examinations and medications. The Frisco ISD workers' compensation program pays for healthcare reasonably required using evidence-based medicine in accordance with the Official Disability Guidelines (ODG) to treat a compensable injury. Workers compensation claims should not be processed via personal health insurance.

The Frisco ISD Employee Health Benefit Plan will not cover any expenses for which you should be receiving workers' compensation benefits, and you cannot use your prescription card for medications related to your injury.

Workers' compensation benefits apply only if the claim is found to be compensable. If a claim is reported more than 30 days after it occurs, benefits may be denied or disputed if the employee does not report the injury.

Process for Workers' Compensation Claims:

If you are injured at work, think the injury was caused by work, or a doctor tells you the injury/illness is work-related, the following steps must be taken:

1) You must immediately report the incident to your school nurse, your supervisor, or workerscomp@friscoisd.org. The campus Nurse or supervisor will need to fill out form DWC-1. Employee fill out the Claims Administrative Services (CAS) Workers' Compensation Supplemental Injury Report. You may be asked questions to enable the Nursing, Payroll or Risk Management staff to complete the state-required employer's first report of injury. We will need to know what, when, and where the injury occurred, who was involved, what part of your body was injured, what caused the accident, and who saw it happen.
2) A list of workers comp providers included, primary treating physicians, you can go to if you need to seek medical services. Workers compensation claims should not be processed via personal health insurance. To be referred to a specialist, employees must first be seen by a treating practitioner. Within 60 days of the injury the employee has the right to change treating doctors.
3) If you receive any medical bills relating to your workers compensation injury they will need to be submitted to workerscomp@friscoisd.org immediately so they can be sent to the districts workers compensation administrator, Claims Administration Services (CAS), to be processed.
4) If you have any questions or need information relating to your claim contact: workerscomp@friscoisd.org

Janet Leonardo
leonardoj@friscoisd.org
FISD Workers' Compensation
Administrator Central Administration
Direct Line: 469-633-6345

Dafne
workerscomp@friscoisd.org
FISD Workers' Compensation Specialist
Central Administration
Direct Line: 469-633-6346
Fax Number: 469-633-6325

5) Per Workers Compensation laws, the Frisco ISD does not pay injured workers for the first seven days off work. However, you may choose to use your accrued leave time for the seven-day waiting period considered salary continuation (the days will not be retroactively paid when option one or two is elected in the election of benefits letter). If you are off for more than 14 days, workers' compensation will retroactively pay the first 7 days when option three is elected in the election of benefits letter. If the employee does not lose more than 7 days and does not have any personal leave time available their payroll may be docked. After the seventh day of absence with no election of benefits letter on file, the district workers' compensation program will pay 70%to 75% of the employee's average weekly wage, subject to the maximum and minimum amounts established by law. This is not salary or a paycheck. It is called Temporary Income Benefits (TIBS).
6) For determining the amount of Temporary Income Benefits of a school district employee under Chapter 504, the average weekly wage is computed on the basis of wages earned in a week rather than on the basis of wages paid in a week. Temporary Income Benefits equal 70 percent of the difference between your average weekly wage and the wages you are able to earn after your work-related injury. The amount of Temporary Income Benefits is subject to a maximum of **$1,174** and minimum of **$176** benefit amounts.
7) If you are receiving Temporary Income Benefits (TIBS) for an extended period of time and pay child support notify Workers' Compensation Department immediately. The Frisco ISD Payroll Office will need to submit paperwork to the state and to the workers compensation administrator, Claims Administration Services (CAS), to start deducting the child support from your TIBS check.
8) You will need to pay close attention to your payroll and time sheet as it relates to your claim. It is your responsibility to keep track of the days or times used to treat the compensable injury and communicate that information in a timely manner. Depending upon the nature & duration of the claim, the workers' compensation program requires complex payroll calculations to submit accurate wage statements and reports to the State.
9) You will receive many documents regarding your claim. These will be mailed to your home address. Keep copies of anything you give to your assigned adjuster or send to the DWC. Note: Make sure you fill out the employee's report of injury form; this is form DWC-41. You should receive this directly from the DWC within the first 6 weeks after your injury. If you do not receive it in the first 6 weeks after your injury, contact the DWC at the number below and request a form. It is important to complete this form and return it to the DWC.
10) You should report to your supervisor each time you go to the doctor. The doctor should give you a work status report DWC-73 form after the appointment. If you're treating doctor releases you to return to work with modified physical restrictions, you will need to contact your supervisor ans the Workers' Comp. Department to see if FISD will be able to accommodate your restrictions. An employee is required to have a return to work release form from their attending physician in order to return to their full regular duties. For questions regarding return to work contact your departmental supervisor or Janet Leonardo @ extension 36345.

The FISD Workers Compensation program is administered by:

Claims Administrative Services
Phone: 1-800-765-2412
Email: claimsmail@cas-services.com
Fax: 1-903-509-1888
501 Shelley Drive
Tyler, Texas 75701

Additional information may be obtained from:
https://www.tdi.texas.gov/index.html
The Texas Department of Insurance
1601 Congress Avenue, Austin 78701 • P.O. Box 12050, Austin 78711
(512) 804-4000
Division of Workers' Compensation Customer Services 800-252-7031

Workers' Compensation Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 7-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____/_____/_____
MM/DD/YYYY

Group #: PAWA

Employee Date of Birth: _____/_____/_____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor: Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

Frisco ISD

Participating Retail Network Pharmacies

myMatrixx
An Express Scripts Company

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Fred's
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
Harris Teeter
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
Kroger
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Walmart
Wegmans
Weis
Winn Dixie

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system**. If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Frisco ISD

Optimum care™

All employees are permitted by the Workers' Compensation Act to choose any doctor that accepts workers' compensation insurance. **Optimum Care** physicians and facilities are pre-screened based on several quality indicators and are experienced in treating work-related injuries. These providers have agreed to treat your compensable work-related injury in the timeliest manner.

If you are injured at work...

- **In emergencies, call 911 and seek immediate treatment from the nearest qualified facility or provider.**
- Notify your immediate supervisor that an injury has occurred.
- If you require non-emergency-related medical attention, we have made arrangements with the pre-approved providers listed below.
- For urgent care needs after clinic hours, you may proceed directly to the nearest hospital emergency room.

Approved Physicians:

Concentra
8756 Teel Parkway, Ste. 350
Frisco, TX 75034
972.712.5454

Care Now
301 West Main Street
Frisco, TX 75034
972-335-0030

Care Now
5644 Preston Road
Frisco, TX 75035
972.529.4545

Legacy ER
9205 Legacy Drive
Frisco, TX 75034
972-688-6020

Legacy ER
16151 Eldorado Pkwy
Frisco, TX 75035
972.731.5151

Optimum Care is NOT a Certified Network

For questions regarding your claim or if you need an alternative to the providers listed here, please contact:

800.765.2412