

Workers' Compensation Employee Packet

Complete the following forms and return to Meagan Voorhies, Claims Coordinator via fax (817) 735-0127, email at Meagan.Voorhies@untsystem.edu or in person at Human Resource Services (EAD-280).

- **Workers' Compensation Network Acknowledgment**
 - Employee Notice of Network Requirements packet is provided on HRS Webpage
- **Employee's Report of Injury (SORM-29)**
 - Must be filed no later than the third calendar day after the first notice of injury
- **Authorization for Release of Information (SORM-16)**
 - Must be filed no later than the third calendar day after the first notice of injury
- **Employee's Election Regarding Utilization of Sick & Annual Leave (SORM-80)**
 - Must be filed no later than the third calendar day after the first day of lost time
 - Detailed instructions on election choices attached
- **Witness Statement (SORM-74)**
 - This form should be completed by the witness (if applicable)

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)

I live at _____
(Street Address)

(City)

(State)

(Zip Code)

Name of Employer _____

Name of Network _____



EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have 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: _____ <small style="display: inline-block; width: 100px; text-align: center;">Last First MI Maiden</small> Address: _____ City: _____ State: _____ 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 (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) Name _____ Phone: _____ Name _____ Phone: _____ Name: _____ Phone: _____	
7) Please identify 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when was the first day you missed work? _____	
10) If the doctor took you off work, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, when do you think you will return to work? _____	
11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____	
12) Have you had previous workers compensation injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please enter dates of injuries and the body parts injured.	
By affixing my signature, I attest that all information on this form is accurate and true.	
Signature: _____ Date: _____	

Instructions Employee's Report of Injury

Purpose of Form:

The injured employee completes this form to provide SORM with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury. This will help to expedite benefits in a more timely manner.

Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the First Report of Injury or Illness (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 is to 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 providers names and phone numbers and work status is needed. The employee should enter any previous workers compensation claims and the 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
PO 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.



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) _____

Photostatic copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

SIGNED: _____ DATED: _____

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

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, from healthcare providers, copies of relevant medical documents that will assist in the handling of the claim.

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:

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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EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE FOR GENERAL EMPLOYEES

Employee's Name _____ Date of Injury _____

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. Accrued 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.

Complete Election 1 or Election 2.

ELECTION 1 (must choose A, B, or C) Sick leave must be exhausted before annual leave may be used

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 of hours: _____).
C. None of my accrued annual leave.

ELECTION 2

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

I understand that I may not change my election after my eighth (8th) day of disability and signing this form. I have read the reverse side of this form, and I fully understand the election I am making.

Hours of Sick Leave Hours of Annual Leave
Employee's Social Security Number Agency
Employee's Signature Date Claims Coordinator's Signature Date

This form may not be altered in any way.

Instructions Employee's Election Regarding Utilization of Sick and Annual Leave For General Employees

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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WITNESS STATEMENT

**MUST BE TYPED
OR PRINTED**

Injured Employee _____

SORM Claim Number WC _____

Date of Injury _____

Statement Taken By _____

Witness Name: _____ Witness email address: _____

Residence Address: _____

Primary Telephone: _____ Secondary Telephone: _____

Witness Employer: _____

On this date, _____, at about _____ PM / AM I was in or at (clearly state your own location) _____ when an accident involving the above employee is reported to have occurred.

Check only one box

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

Other pertinent information and source: _____

I did not see the incident. Information given to me by (name of person) _____ indicates it occurred as follows: _____

Other pertinent information and source: _____

I know nothing whatsoever about the occurrence.

Signature

Date

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. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
2. Please provide the SORM claim number, if known.
3. 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. Check the first or second box and fill in the blanks following those boxes, as appropriate. Be specific and complete. Sometimes you will be given a witness name but, when asked, denies any knowledge of the incident. In such a case the third box should be checked.
4. If the space provided on the form is insufficient please attach additional sheets. Be as specific and complete as possible.

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