BARBERS HILL INDEPENDENT SCHOOL DISTRICT
****EMPLOYEE INJURY REPORT****

THE FOLLOWING INFORMATION IS NECESSARY TO FILE THE "EMPLOYER'S FIRST REPORT OF INJURY." PLEASE COMPLETE ALL SECTIONS AND RETURN TO THE BUSINESS OFFICE WITHIN 24 HOURS.
PLEASE CALL 281.576.2221 x 1284 WITH QUESTIONS.

ALL ACCIDENTS SHOULD BE REPORTED IMMEDIATELY TO THE SUPERVISOR

Last Name: _____ First Name: _____ Phone: _____
Address: _____ Marital Status: _____
City: _____ Zip: _____ Date of Birth: _____
Gender: ☐ Male ☐ Female Number of Dependent Children: _____ Last 4 of SSN: _____
Job Title: _____ ☐ F/T ☐ P/T Supervisor: _____
Employee Start Time: _____

DATE OF INJURY: _____ TIME OF INJURY: _____ ☐ am ☐ pm
TYPE OF INJURY/ILLNESS: _____
PART OF BODY INJURED: _____ ☐ LEFT ☐ RIGHT
DEPARTMENT/LOCATION WHERE INJURY OCCURRED: _____
INJURY DESCRIPTION: _____
WORK PROCESS EMPLOYEE WAS ENGAGED IN: _____
DATE LOST TIME BEGAN: _____ WITNESS NAME: _____
LAST WORK DATE: _____ APPROXIMATE LENGTH OF DISABILITY: _____

SCHOOL NURSE NOTES: _____

IF DOCTOR'S SERVICES WERE REQUIRED, NAME AND ADDRESS OF PHYSICIAN/HOSPITAL:

_____

FOLLOW-UP TREATMENT REQUIRED? ☐ YES ☐ NO

_____
SIGNATURE OF EMPLOYEE DATE

_____ PHONE #: _____
SIGNATURE OF SUPERVISOR OR NURSE DATE

EXAMINATION/TREATMENT REFUSED:

_____ DATE/TIME: _____
SIGNATURE OF INJURED PARTY

_____ DATE/TIME: _____
SIGNATURE OF WITNESS (IF ANY)

[OFFICE USE ONLY]
DOH: _____ **Daily:** _____ **Gross:** _____

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. 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 to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ _____/_____/_____

Signature Date

_____

Printed Name

I live at: _____

Street Address_____

_____

City, TX, Zip

Employer Name: Barbers Hill ISD

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance) Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:_____/_____/_____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

RECONOCIMENTO DEL EMPLEADO PARA EL PROGRAMA DE CONTRATAR DIRECTAMENTE CON MEDICOS

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tartar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escojer de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

Signature (Firma):_____ Date (Fecha):____/___/_____

Printed Name (Nombre en imprenta): _____

Address (Direccion de domicilio incluindo cuidad, estado y zip):

_____

Employer (Nombre de empleo): Barbers Hill ISD

Name of Direct Contracting Program (Nombre del programa de contratar doctores directament): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: www.pswca.org o llame a su ajustador al numero: 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:____/_ _/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name_____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

_____

_____(member organization) workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB
P.O. Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eBill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature_____ Title _____

Phone Number 281.576.2221 Date _____

Providers please submit Work Status Reports and all Job Description inquiries to:

Contact Name, Title Sandra Westerberg

Phone

Fax 281-576-3424

Email swesterberg@bhisd.net

For a full list of Alliance Providers please visit pswca.org.