

WORKERS' COMPENSATION
PROGRAM

CRE-P
(REGULATION)

PROGRAM	The San Elizario Independent School District (SEISD) is self-insured for its workers' compensation program. Claims Administrative Services, Inc. (CAS) serves as the District's third party administrator (TPA) and handles all the workers' compensation claims. Any employee that sustains an injury or an occupational disease during the course and scope of employment is covered by SEISD's workers' compensation program.
REPORTING REQUIREMENTS	To comply with the Texas Workers' Compensation Act and the Texas Workers' Compensation Division's rules, SEISD has put forth specific actions that employees and district personnel should initiate when an accident or injury occurs and/or when a claim for Workers' Compensation benefits is filed.
EMPLOYEE REPORTING	Employees should report a work-related injury as soon as practical to their immediate Principal/Supervisor. The immediate Principal/Supervisor and injured employee must fill out and sign an Injury/Accident Report (Exhibit A). The campus nurse should also fill out their corresponding section on the Injury/Accident Report (Exhibit A). This report should be submitted to the Risk Management Coordinator within 24 hours after the injury occurs, or the following Monday if a weekend is involved. Failure to do so may result in disciplinary action. The Principal/Supervisor will advise the Risk Management Coordinator if the injured worker is seeking medical attention. A doctor's note is required any time an employee is seen by the doctor if taken off work or is returned back to work.
SEISD REPORTING	The district shall report to the TPA if an injury results in the employee wishing to seek medical attention, an injury results in the employee being absent from work for more than one day and/or any required report requested by the insurance carrier. An accident investigation should be conducted by a campus/facility representative or the Risk Management Coordinator. The Risk Management Coordinator shall follow-up on the investigation, verify all medical treatment with the treating physician, provide assistance to the Principal/Supervisor and the injured employee. In addition, the Risk Management Coordinator shall communicate all worker's compensation leaves to the payroll department, the Human Resources Director and the Principal/Supervisor.
RETURN TO WORK – MEDICAL ONLY CLAIMS	Employees seeking medical attention for a work-related injury and that are released to return back to work shall bring the doctor's note to the Risk Management Coordinator BEFORE returning to the work site. The Risk Management Coordinator will issue a return to work permit if there are no restrictions. If restrictions are issued, the coordinator will consult with the Principal/Supervisor to determine if the injured employee can be allowed to return to work under the District's modified duty program.

RETURN TO
WORK – LOST
TIME CLAIMS

Employees seeking medical attention for a work-related injury and placed on a no work status shall:

- Bring the doctor's note to the Risk Management Coordinator
- Notify the Principal/Supervisor of their no work status
- Be placed on FMLA if taken off work for more than 5 days, FMLA leave shall run concurrently with Workers' Compensation leave
- Bring a current doctor's note on a monthly basis to the Risk Management Coordinator
- Upon being released to return to work, bring the doctor's note to the Risk Management Coordinator BEFORE returning to the work site and receive a return to work permit.

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT INJURY/ ACCIDENT REPORT

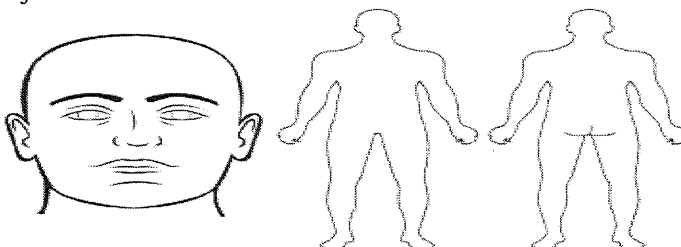
INSTRUCTIONS: This form is for internal use only and should be used for reporting a work-related injury or illness. Call the Risk Management Office at 872-3900, ext 3305 immediately after an accident has been reported. This report should be completed by the Campus Principal or Department Supervisor and by the injured employee and must be submitted within 24 hours. Attach additional sheets as needed.

Name of Injured Employee: _____	Campus/ Department _____
Last 4 Digits of Social Security Number: _____	Title/Occupation: _____
Address, City, State, Zip Code: _____	Phone: _____
Date and Time Of Injury: _____	Date and Time Reported: _____
Was Medical Treatment Required? ____ Yes ____ No ____ Unknown	Was the Employee Absent Due To This Injury? ____ Yes ____ No ____ Unknown

TO BE COMPLETED BY INJURED EMPLOYEE

Briefly describe how the injury occurred:

Circle Part of body that was injured



Employee Signature: _____ Date: _____

TO BE COMPLETED BY WITNESS

Describe what you observed

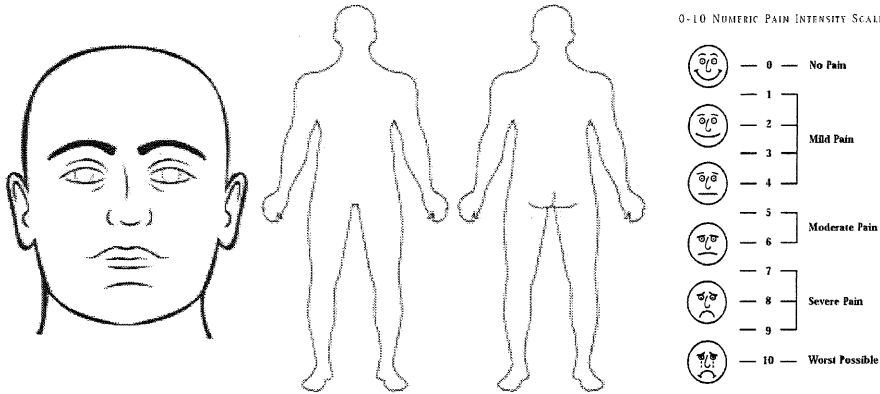
Witness Signature:

Date:

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT INJURY/ ACCIDENT REPORT

TO BE COMPLETED BY NURSE

Nurse's Interventions:



Nurse's Signature: _____ Date _____

TO BE COMPLETED BY PRINCIPAL OR DEPARTMENT SUPERVISOR

Briefly describe WHAT the employee was doing at the time of the Injury/Accident?

Briefly describe WHERE the incident occurred. Include any surroundings, environmental, or physical concerns that might have contributed to the injury?

Was the employee violating SEISD safety policies or procedures? ____ Yes ____ No
If yes, describe the non-compliance:

What can be done to prevent similar incidents?

Signature: _____ Date: _____