SANTA FE INDEPENDENT SCHOOL DISTRICT
P. O. Box 370
Santa Fe, Texas 77510

PHONE AND FAX: (409)925-9024
www.sfisd.org

Becky Wright
Coordinator of Benefits and Risk Management
becky.wright@sfisd.org

SUPERVISOR INSTRUCTIONS

What to Do When an Employee is Injured On-the-Job:

An employee must report any on-the-job injury to the campus nurse or his/her supervisor by the conclusion of the work day. The affected school or department must report all on-the-job injuries and/or work-related illnesses to the SFISD Benefit Office at 409-925-9024 within twenty-four (24) hours.

Any injury or illness must be reported, even if no medical treatment is sought.

Procedures for Supervisor:

*****Do not hesitate to call 911 for emergency assistance*****

1. Fill out attached "Employers First Report of Injury or Illness" form. *Employee is NOT to complete this form*. Complete boxes 1-29, box 35, sign and date in box 51.

2. If employee is able, have them fill out Employee Statement (form attached)

3. If witness available, have them fill out Witness Statement (form attached)

4. Fill out "First Fill Information", keep a copy, and give original to employee.

5. Have employee fill out "Employee Election/Leave Benefit" form if they are able.

6. Give the employee:

    a. A copy of the First Report of Injury
    b. If medical treatment is needed, a copy of the "WellNow Health Employers Authorization for Examination or Treatment" form.
    c. Completed "First Fill Information" form

7. Send all future work status reports and documentation to the Benefits Office.

Scan all forms to Benefit Office (becky.wright@sfisd.org), keep a copy for your records, and send originals in inter office mail.

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.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -	18. Nature of Injury*	19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? YES ☐ NO ☐	If No, Specify Language		20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
City	State	Zip Code County	Street or P.O. Box	County	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City	State	Zip Code
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box)			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) - -
City	State	Zip Code			

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	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 ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form		41. Name of Business Santa Fe ISD	
42. Business Mailing Address and Telephone Number Street or P.O. Box PO BOX 370	Telephone (409) 925-9024	43. Business Location (If different from mailing address) Number and Street N/A	
City SANTA FE	State TX	Zip Code 77510	City N/A / State / Zip Code N/A
44. Federal Tax Identification Number 7460000288	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company DEEP EAST TEXAS / TRISTAR		49. Policy Number	

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 _____

EMPLOYEE STATEMENT

Employee Name: _____ Date of Injury: _____

Description of accident:

_____

_____

_____

_____

_____

_____

_____

_____

Was lifting involved in this accident? ☐ Yes ☐ No If yes, approximate weight of item lifted: _____

Was anyone assisting you? ☐ Yes ☐ No

If yes, explain: _____

What was the nature of your injury? (cut, bruise, strain, etc.)_____

What part of your body was injured? (finger, knee, etc.) _____

Was there any equipment involved? ☐ Yes ☐ No If yes, describe: _____

What could you have done to prevent the accident? _____

Were you performing your normal job duties at the time of the injury? ☐ Yes ☐ No

If no, explain: _____

Was personal protective equipment (cloves, goggles, hardhat, etc.) required for this job? ☐ Yes ☐ No

If yes, was the equipment provided? ☐ Yes ☐ No Was it being used? ☐ Yes ☐ No

Explain: _____

Was the accident witnessed? ☐ Yes ☐ No List witness(es): _____

_____

The above information is a true and correct account of the incident.

_____ _____

Signature of Employee Date

WITNESS STATEMENT

Injured Employee: _____ Date of Injury: _____

Name of Witness: _____ Witness Phone Number: _____

Relationship to injured worker: _____

Description of accident:

_____

_____

_____

_____

_____

_____

Other employees involved in accident: _____

Were you in the area where the accident happened? ☐ Yes ☐ No

Did you see the accident happen? ☐ Yes ☐ No

Was it obvious that the employee was hurt? ☐ Yes ☐ No

Was the employee using a tool or machinery when injured? ☐ Yes ☐ No

Have you ever heard the employee complain of a similar injury? ☐ Yes ☐ No

Did the employee violate a safety rule? ☐ Yes ☐ No

Was the employee ever warned about unsafe work habits? ☐ Yes ☐ No

Where did it happen? _____

What part of the body appeared to be injured? _____

What do you think was the cause of the accident? _____

What do you think could have prevented the accident from happening? _____

The following is my statement of what I heard the injured employee say:

_____

Additional comments:

_____

_____

The above statement is a true and correct account of what I observed and heard.

_____ _____

Witness Signature Date

wellnow HEALTH

Fax or email authorization forms **wellnowhealth@wellnowhealth.net**

676 F.M. 517 West
Dickinson, Texas 77539
Phone: 409.572.2535
Fax: 409.572.2480
8am to 7pm (Mon-Fri)
9am-2pm (Sat)

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SSN: _____

Company Name: _____ Date of Birth: _____

Site #/Street Address: _____ Date of Injury: _____

WORK-RELATED ___INJURY ___ILLNESS

___Drug Screen
___Breath Alcohol
___Drug Screen and Breath Alcohol
___Urine Collection Only
___DOT Regulated
___Non-Regulated
___Rapid D/S (instant)

___DOT PHYSICAL ___NON DOT PHYSICAL

___Pre-placement (Post-Offer)
___Recertification (Annual)
___Exit
___Audiogram
___Regulated Drug Screen
___Urine Collection Only
___Breath Alcohol

PRE-PLACEMENT EVALUATION

JOB TITLE: _____

___Physical Exam
___Physical Assessment
___Regulated Drug Screen
___Non-Regulated Drug Screen
___Urine Collection Only
___Hair Collection
___Audiogram
___Fit Test
___Mask Type _____
___PFT Test

SUBSTANCE ABUSE TESTING

___DOT Regulated
___Non-Regulated
___Urine Collection Only
___Rapid Test
___Pre-Placement
___Reasonable Suspicion
___Random
___Periodic
___Post-accident
___Follow-up
___Breath Alcohol

SPECIAL PHYSICAL EXAMINATIONS

___Asbestos
___Respirator
___Hazmat
___Baseline
___Blood work _____
_____
___Other
_____

BILLING

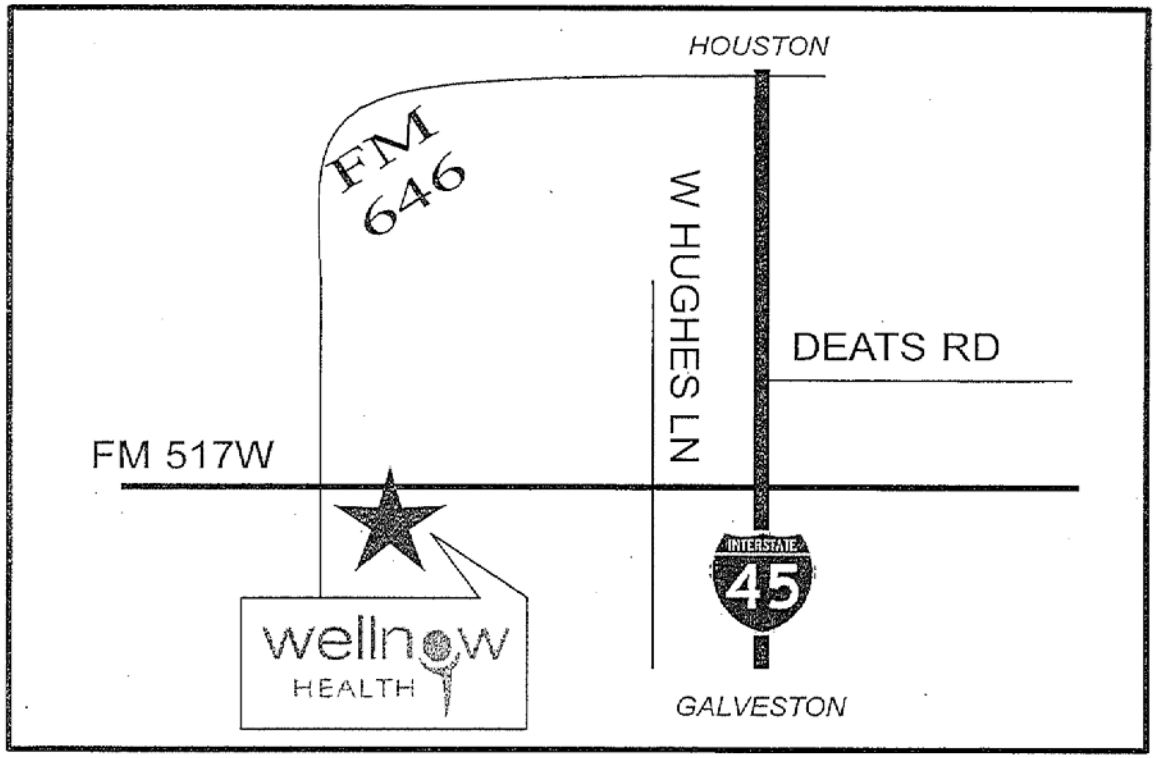
___Employee to pay charges at time of service
___Workers Compensation
Insurance Co: _____
Policy #: _____
Phone #: _____

Authorized By: Becky Wright Title: Coordinator of Benefits and Risk Management

Phone: 409-925-9024 Date: _____

Form may be downloaded from **www.wellnowhealth.net**

676 F.M. 517 West
Dickinson, Texas 77539
Phone: 409.572.2535
Fax: 409.572.2480
8am to 7pm (Mon-Fri)
9am to 2pm (Sat)



Form may be downloaded from **www.wellnowhealth.net**

INSTRUCTIONS FOR PRESCRIPTION BENEFIT CLAIMS

Dear Injured Worker:

The below temporary COMP+ prescription benefit card will authorize you to obtain prescription medications for your work-related injury, with no out-of-pocket expense. The card will be activated when the pharmacy processes the prescription medication along with all necessary information. Once activated, it will authorize you to obtain prescription medications that are directly related to your work injury. *NOTE: there may be limitations to how much of your prescription may be dispensed, based on various elements such as jurisdictional and/or other restrictions in place for your employer's prescription benefit plan.*

Please note that this card is to be used only for prescriptions related to your work injury. Should you attempt to use it for other prescriptions not related to the work injury, it will become your responsibility to pay for those prescriptions. Please avoid having any prescription related to your work injury filled directly by the prescribing physician's office, as most physicians do not accept prescription benefit cards for billing purposes.

You may fill your prescriptions at the COMP+ network pharmacy of your choice, which includes all of the major retail pharmacies. Need help finding your nearest network pharmacy? Call COMP+ at 1-866-337-6426 for assistance. For other questions regarding your work-related injury, please call 1.888.55TRISTAR (1.888.558.7478) to contact your TRISTAR claim examiner.

Your temporary COMP+ prescription benefit card contains important claims and customer service information for you and your pharmacist. Please present the lower portion of this letter to your pharmacist when filling any prescription related to your work injury. A permanent card may be mailed to replace this temporary card.

OnePoint® COMP+ TRISTAR®

Workers Compensation Rx Benefit Card

Rx BIN: 610243
Rx PCN: WC
Rx Group: TMCMOFTXT2
Rx ID: TMC01

This card is for Pharmacy Benefits Managed by OnePoint Patient Care

First Fill Only

Employee Name: _____
Employer Name: SANTA FE ISD
Injury Date: _____

Present this card along with your prescription when ordering your medication. If you have any questions regarding your pharmacy benefit program, please call Customer Service 7 days a week/24 hours a day.

For Employees/Pharmacists: 866-337-6426

Card Instructions: Pharmacy should submit claims using the workers' compensation claim segment. This is an interim prescription benefit card and can only be used for an injured worker's first prescription fills.

Card will activate upon prescription submission

If you have any issues filling a prescription, please contact the Pharmacy Help Desk number listed above.

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INSTRUCCIONES PARA LAS SOLICITUDES DE BENEFICIOS DE RECETAS MÉDICAS

Para el/la trabajador/a lesionado/a:

La tarjeta temporal de beneficios de recetas médicas de COMP+ que se encuentra adelante le permitirá obtener los medicamentos recetados para su accidente de trabajo sin costos adicionales. La tarjeta se activará cuando la farmacia procese el medicamento recetado junto con toda la información necesaria para la administración de los beneficios de la farmacia. Una vez activada, podrá obtener los medicamentos recetados en particular para su accidente de trabajo. *NOTA: pueden haber limitaciones en cuanto a la cantidad de recetas médicas que se pueden brindar. Esto puede depender de distintas condiciones como las restricciones jurisdiccionales o de otro tipo establecidas para el plan de beneficios de recetas médicas de su empleador/a.*

Recuerde que esta tarjeta solo deberá utilizarse para las recetas médicas para su accidente de trabajo. Si intentase utilizarla para cualquier otra receta médica no relacionada con su accidente de trabajo, será su responsabilidad pagar aquellas recetas. Evite obtener cualquier receta médica para su accidente de trabajo en un consultorio médico, ya que la mayoría de los/las médicos/as no aceptan tarjetas de beneficios de recetas médicas por motivos de facturación.

Puede solicitar sus recetas médicas en cualquier farmacia de la red COMP+ que desee, que incluye todas las farmacias minoristas principales. ¿Necesita ayuda para encontrar la farmacia más cercana a su domicilio? Llame a COMP+ al 1-866-337-6426 para obtener más ayuda. Si tiene otras preguntas relacionadas con su accidente de trabajo, llame al 1.888.55TRISTAR (1.888.558.7478) para comunicarse con un/a administrador/a de reclamos de TRISTAR.

Su tarjeta temporal de beneficios de recetas médica de COMP+ contiene datos importantes e información de servicio al cliente para usted y su farmacéutico. Entréguele la parte inferior de esta carta a su farmacéutico al momento de solicitar cualquier medicamento recetado para su lesión laboral. Es posible que reciba por correo una tarjeta permanente para reemplazar esta tarjeta temporal.

OnePoint® COMP+

TRISTAR®

Workers Compensation Rx Benefit Card

Rx BIN: 610243
Rx PCN: WC
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This card is for Pharmacy Benefits Managed by OnePoint Patient Care

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Employee Election / Leave Benefit

Name_____ **Employee phone number** _____

Position_____ **Department/Campus**_____

This employee is absent from duty because of a job-related illness or injury beginning on _____. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____
District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only_____days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ❑ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from SFISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____
Employee signature Date