

CAMPUS - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

*For Emergencies please direct employee to nearest Emergency Room or Clinic. If possible ensure Employee leaves with **Verification of Employment for Reported WC Claim** (Page 2) **Optum First Fill® Card** (Page 3 & 4) and contact Human Resources immediately*

- ☐ You must ensure a **First report of Injury** is completed with or with or without the employee's assistance! **Go to this link at www.tasbrmf.org and complete First Report of Injury** and file no later than the next business day. You do not need to log in to complete the First Report of Injury. (Complete with as much information as you have, see instructions on pages 9-17)
- ☐ Have the employee sign **Acknowledgment of Medical Alliance** (Pages 5 & 6)
- ☐ If Employee feels he/she may seek medical treatment complete and give the **Verification of Employment for Reported WC Claim**(Page 2) and **Optum First Fill® Card**(Page 3 & 4)
- ☐ Have Employee advise whether he/she wishes to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form. (Page 7 & 8)

Email or Fax all signed forms and paperwork by the next business day to:

Rosario Lopez, Benefits Analyst
Phone: 409.989.5252
Fax: 409.989.6175
Email: rosario.lopez@paisd.org

Please refer injured employee directly to Human Resources for any further questions or issues regarding any workers' compensation injury. **Alert Rosario Lopez immediately if employee misses any time, returns to work, or if there are any questions or concerns.**

To search for primary care physicians in your area go to **the Find A Doctor link** at the Political Subdivision Medical Alliance www.pswca.org website.

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.



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 _____

Date _____

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

Contact Name, Title

Phone

Fax

Email

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

MAKING IT EASY... TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:



If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.



If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.




Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTE: This First Fill card is only valid for your workers' compensation injury or illness.



Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:



Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.



Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.




La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

**¿Tiene alguna pregunta?
¿Necesita ayuda?**



1-866-599-5426



WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

PORTADORA

EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Por favor provea directamente al farmacéutico

NUMERO DE SEGURO SOCIAL

FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTA: Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.



Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

Employee Acknowledgement 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, State, Zip Code

Name of Employer: _____
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 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.



Reconocimiento 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 escoger un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necesito 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 escogido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamiento 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 escoger de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

Firma (Signature)

_____/_____/_____
Fecha (Date)

Nombre en imprenta (Printed Name)

Direccion de domicilio incluyendo ciudad, estado y zip (Address)

Nombre de empleo (Name of Employer): _____

Nombre del programa de contratar doctores directament (Name of Direct Contracting Program):
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.



**FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET—ENGLISH VERSION)**

Name _____ Employee number _____

Position _____ Department/Campus _____

This employee is absent from duty because of a job-related illness or injury beginning on (*date of first absence attributable to illness or injury*). 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 Port Arthur ISD 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 receive only 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

For Claims Reporting Purposes Only:

For all employees:

Amount of leave paid to employee: \$ ____.

Daily rate: \$ _____

Period of payment: from ____/____/____ through ____/____/____
for ____ days **or** ____ weeks

For hourly employees only:

Hourly rate: \$ ____.

Number of hours paid: _____



**FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET—SPANISH VERSION)**

Nombre _____ **Número de empleado** _____

Posición _____ **Departamento/campus** _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en (fecha de la primera ausencia que se atribuye a enfermedad o lesión). Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

Firma autorizada de distrito

Fecha

Elección del empleado:

Estoy ausente del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ☐ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.
- ☐ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabado toda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalente a mi sueldo previo a la enfermedad o a la lesión.
- ☐ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Port Arthur ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

Firma del empleado

Fecha

For Claims Reporting Purposes Only:

For all employees:

Amount of leave paid to employee: \$ ____.

Daily rate: \$ _____

Period of payment: from ____/____/____ through ____/____/____ for
_____ days **or** _____ weeks

For hourly employees only:

Hourly rate: \$ ____.

Number of hours paid: _____



How to File a First Report of Injury

Campus or Department Instructions

Start here: tasbrmf.org/claims

TASB RISK FUND

About Us | Contact Us | Report a Claim | Login

Programs | Member Service Center | Learning & News

Connect with us: [f](#) [t](#) [in](#)

Auto
Liability
Property
Privacy & Information Security
Unemployment Compensation
Workers' Compensation
[Get a Quote](#)

Report a Claim

Report a Claim

If you need immediate assistance, please call 800.482.7276. Calls are answered 24/7, including after hours and on the weekends. If you call outside of business hours, our answering service will contact an adjuster and you will receive a call within one hour.

Jump to: [Auto](#) | [Liability](#) | [Property](#) | [Cyber](#) | [Unemployment compensation](#) [Quarterly Wage Statement](#)

Workers' Compensation claims

First Report of Injury

- Program administrators who do not use the FROI Administration application, or
- Campuses and departments who need to report an employee injury to their organization's workers' compensation program administrator:

First Report of Injury WC Claim

Please type in your organization below to report a worker's compensation First Report of Injury

Organization

Report a WC Claim

Type your organization into the search bar and then click here.

First Report of Injury guides

- [How to File a First Report of Injury \(PDF\)](#)
- [How to File a First Report of Injury for Campus or Department \(PDF\)](#)
- [FROI Administration Guide \(PDF\)](#)

myTASB Access

myTASB You must have a myTASB user ID and password to access some resources. If you need access, speak with your program contact —the person in your organization responsible for granting user rights. For more information, visit our [myTASB Access page](#).

Your Marketing Consultant

Want to know more about what the Fund can do for you?

Your [marketing consultant](#) can connect you to experts on training, loss prevention resources, and additional programs that can lower your exposure to risk.

**TASB
RISK
FUND**

Reporting a Claim [Log Out and Exit](#)

What you will need:

- Basic information about what happened, including date, location, etc.
- Additional details about the employee who was injured, such as name, address, and wage information

What you should know:

- The reporting form will timeout after 120 minutes of inactivity.
- You can find detailed instructions on how to report a workers' compensation claim [in this guide](#).


When you are finished filling out the First Report of Injury (FROI) on the next page, be sure to click on the "Save Changes" button at the top of the page to submit to TASB.

[Start a FROI](#) Click here to start your FROI.

[Chat now](#)

Important: Please note that all items marked with a red asterisk (*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

Any placeholders or incorrect information will be corrected by your administrator upon submission.



New First Report of Injury
Complete Incident or Cancel

Employer General Information

Member	Education ISD		
Physical Address	123 1 st Street	Mailing Address	PO Box 123
City	Your City	City	Your City
State	Texas	State	Texas
ZIP	00000	ZIP	00000
FEIN	12345678		
Phone	(123) 456 7890		

Is this a corrected copy? * No

If you have already submitted a FROI to your administrator please call or email them to advise of any changes or additions prior to filing a corrected copy.

Insured Report Number

Location * ADMINISTRATION (Main Memb Q

Did injury or illness exposure occur on employer's premises? No

If your organization uses employee numbers, you may enter the injured employee's number here. If not, leave this blank.

Click on the magnifying glass to select the applicable location from the list.

If the injury occurred off campus, select "No" and enter the address of the injury in a box that will appear to the right.

Insured Report Number Q

Location * Q

Did injury or illness exposure occur on employer's premises? No

Since you selected Injury did not occur on employer's premises, please complete the accident address fields to the right.

Address where Injury/Illness Occurred ⓘ

Employee Information

First Name *	<input type="text"/>
Middle Name	<input type="text"/>
Last Name *	<input type="text"/>
Street Address 1 *	<input type="text" value="1"/>
Street Address 2	<input type="text"/>
City *	<input type="text" value="Your City"/>
State *	<input type="text" value="Texas"/>
ZIP *	<input type="text" value="11111"/>
Phone *	<input type="text" value="(555) 111-1111"/>
Work Phone	<input type="text" value="(xxx) xxx-xxxx"/>
Employee Email	<input type="text"/>
Does the employee speak English?	<input type="text"/>

Enter the employee's first and last names in these boxes. The names will populate the Claimant box above.

Please enter the employee's correct mailing address and contact info. If you are uncertain about any information, use these placeholders.

Birth Date *	<input type="text" value="01/01/2010"/>	
Social Security ⓘ *	<input type="text" value="111-11-1111"/>	
Other Employee ID	<input type="text"/>	
Other Employee ID Qualifier	<input type="text"/>	
Hire Date *	<input type="text" value="01/01/2010"/>	
Length of Service Years	<input type="text" value="0"/>	
Length of Service Months	<input type="text"/>	
Hire State *	<input type="text" value="Texas"/>	
Gender *	<input type="text" value="Not Specified"/>	
Marital Status *	<input type="text" value="Unknown"/>	
Occupation/Job Title *	<input type="text" value="Teacher"/>	
Payroll Class Code *	<input type="text" value="PROFESSIONAL/ADMINISTRATIVE"/>	
Occupation Code *	<input type="text" value="PROFESSIONAL/CLERICAL/"/>	
Department Code, if applicable	<input type="text"/>	
Employment Status *	<input type="text" value="Regular/Full-time Employee"/>	
Number of Dependents	<input type="text"/>	

Enter 01/01/2010 if you don't know the employee's date of birth.

If you don't know the employee's SSN, enter 111-11-1111.

Enter 01/01/2010 if you don't know when the employee was hired.

Enter employee's job title and select the employee's appropriate payroll and occupation categories from the dropdown lists.

Please select either regular/full-time or part-time.

Wages

Wage Rate *

1.00

Please enter 1.00. Your administrator will input exact wage rate later.

Wage Rate Type ⓘ *

Daily

Select daily for now. Your administrator will correct this later.

Days Worked Per Week *

5

Hours Worked Per Week

Full Pay On Day Of Injury

Yes

Did Salary Continue?

Please enter 5 days for full time and 1 for substitutes. If necessary, your administrator will correct this.

Gross Amount of Last

Paycheck

Type of Pay ⓘ

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits?

If so, how many leave hours have they elected to use?

Leave these boxes blank for now.

Occurrence Information

Date of Injury/Illness *

10/20/2020



Time Employee Began Work

12:00PM

Time of Injury or Illness

10:00 PM

Exposure *

Date Employer Notified *

10/20/2020



Has the employee lost time or expected to lose time from work?

Was the injury or illness exposure fatal?

Employee's Supervisor

Supervisor Phone Number

(xxx) xxx-xxxx

Type of Injury/Illness *

Contusion

Part of Body Affected *

Knee

Cause of Injury *

Fall, Slip, or Trip - Liquid or Grease

Enter the time and date of injury. If time is unknown, enter 10:00 p.m.

This is the date the secretary, principal, nurse, or supervisor first knew of incident.

Click the magnifying glasses to select the employee's injury, affected body part, and cause of injury from the lists. You can also type the employee's injury/body part or its corresponding code number into the search bar and select from the dropdown lists.

Note: These are national, standardized codes. Choose the option that best matches your incident.

Worksite location of injury ⓘ

Was employee doing their regular job?

Specify activity the employee was engaged in when the injury or illness exposure occurred *

How did the injury or illness exposure occur? ⓘ *

Examples include walking, cleaning, or cooking.

Explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** This space is limited so please be brief.

For example, employee slipped on wet floor in hallway while walking and fell on both knees

Is the employee seeking or expected to seek medical treatment? *

Type of Claim ⓘ *

Record Only is for no medical treatment, no lost time, and no questions or concerns.

Medical Only is for initial medical and/or no more than 5 days of lost time.

Lost Time/Indemnity is for ongoing medical treatment and/or lost time and all other.

Treatment Information

Medical Provider

Physician/Hospital Name

Address

City

State

ZIP

Phone

Fax

Enter doctor/hospital information if known. These are not mandatory fields. Don't worry about inputting addresses.

Initial Treatment *

This field is mandatory. Select the appropriate option from the dropdown list.

Other Information

Date Administrator Notified

10/20/2020



This is the date that the location notifies their FROI Administrator.

Date Prepared *

10/20/2020



Preparer's Name *

John Smith

Preparer's Title *

Supervisor

Preparer's Phone *

(234) 567-8900

Leave this blank for your FROI Administrator to complete.

E-mail address to receive confirmation ⓘ

Please list any known witnesses and their contact information. Do not include student names.

Witness

Witness Phone #

(xxx) xxx-xxxx

All Other Information

You can use this space to enter additional information or alerts for your administrator. This information will not be visible on the FROI.

New First Report of Injury

[Complete Incident](#) or [Cancel](#)

Address

City

State

ZIP

Phone

Fax

Initial Treatment *

Minor clinic/hospital medical re

After you've filled out all the required fields, click here to submit the FROI to your administrator.

Other Information

Date Administrator Notified

10/20/2020



Date Prepared *

10/20/2020



Preparer's Name *

John Smith

Preparer's Title *

Supervisor

Preparer's Phone *

(234) 567-8900

E-mail address to receive confirmation ⓘ

Witness

Witness Phone #

(xxx) xxx-xxxx

All Other Information

Once the form is complete, click on [Complete Incident](#) (located at the top right of the form) to submit the FROI to your TASB FROI Administrator.

[Chat now](#)



Campus or Department Instructions for Filing a First Report of Injury (Updated 2/9/21) - 8 -

TASB RISK FUND
New First Report of Injury

live.origamirisk.com says
Are you ready to complete this incident?
OK Cancel

Employer General Information

Member _____ Education ISD _____

Physical Address 123 1st Street
City Your City
State Texas
ZIP 00000

Mailing Address PO Box 123
City Your City
State Texas
ZIP 00000

FEIN _____
Phone 12345678
(123) 456 7890

Is this a corrected copy? ☐

Insured Report Number _____
Location * ADMINISTRATION (Main Memb)
Did injury or illness exposure occur on employer's premises? ☐

Employee Information

Chat now

TASB RISK FUND
Upload Claim File Documentation

Save Successful

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, Jane R (EV202004398-1) [Upload File](#)

No files uploaded.

I'm done [or Click here to add](#)

Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.

How to Refresh your browser:

Chrome: Hold down Ctrl and press F5

Chrome & Mac: Hold down Command, Shift and click the 'R' key

Firefox & Windows: Hold down Ctrl and press F5

Firefox & Mac: Hold down Command, Shift and the 'R' key

Safari: Hold down the option and command key then press the 'E' key

Internet Explorer: Hold the Control key, press the F5 key.

TASB RISK FUND
Upload Claim File Documentation

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, Jane (20200005506) [Upload File](#)

Filename	Description	Folder	Entry Date
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