STATEMENT OF INJURED

NAME			ADDRESS		
PHONE NUMBER	SOCIAL SECURITY NO.	DATE OF BIRTH	PLACE OF BIRTH	MARITAL STATUS	NO. OF DEPENDENTS
HEIGHT	WEIGHT	HAIR COLOR	EYE COLOR	ANY PREVIOUS HEALTH CONDITIONS CIRCLE ONE: YES NO	
DESCRIBE ALL PREVIOUS DISABILITIES, IF ANY.					
EMPLOYER			ADDRESS		
PHONE NUMBER	JOB TITLE	HOURS/DAY	DAYS/WEEK	SUPERVISOR NAME	
DESCRIBE YOUR JOB				AVERAGE WEEKLY WAGE	
DATE OF ACCIDENT	PLACE OF ACCIDENT				TIME
HOW DID THE ALLEGED ACCIDENT HAPPEN?					
HOW COULD THIS INJURY HAVE BEEN AVOIDED?					
NAMES AND ADDRESSES OF WITNESSES, IF ANY.					
DESCRIBE YOUR INJURY					
DID YOU EVE INJURE THIS PART OF YOUR BODY BEFORE? CIRCLE ONE: YES NO			IF SO, WHEN AND WHERE?		
ATTENDING PHYSICIAN			ADDRESS		
PHONE NUMBER		DATE OF VISIT	NUMBER OF VISITS	HOW OFTEN DO YOU VISIT PHYSICIAN, IF AT ALL.	
WERE YOU HOSPITALIZED AS A RESULT OF THE ALLEGED INJURY? CIRCLE ONE: YES NO			NAME OF HOSPITAL		
ADDRESS				ADMISSION DATE	DISCHARGE DATE
WERE YOU COMPELLED TO STOP WORK AS A RESULT OF THE ALLEGED INJURY? CIRCLE ONE: YES NO			LAST DAY WORKED		
HAVE YOU RETURNED TO WORK? CIRCLE ONE: YES NO		DATE OF RETURN	AT WHAT WAGE	AT WHAT JOB	AT WHAT JOB TITLE

Signed: Date

Address

SUPERVISOR'S INCIDENT REPORT

NAME OF INJURED EMPLOYEE

REPORTING SUPERVISOR NAME

DATE OF ALLEGED INCIDENT

TIME OF ALLEGED INCIDENT

EXACT LOCATION OF ALLEGED INCIDENT

DEPARTMENT

JOB TITLE

JOB SITE

DATE OF HIRE

WAS PHYSICIAN CONTACT NECESSARY

CIRCLE ONE: YES NO

IF YES, DATE OF NOTIFICATION:

PHYSICIAN NAME

PHONE NUMBER

FACTS OF INCIDENT: (DESCRIBE AS DETAILED AS POSSIBLE WHAT HAPPENED - IF AN INJURY RESULTED, PART OF BODY INJURED, NATURE OF INJURY)

WERE THERE WITNESSES?

CIRCLE ONE: YES NO

IF YES, NAME OF WITNESS

IF YES, NAME OF WITNESS

DEPARTMENT

DEPARTMENT

JOB TITLE

JOB TITLE

PHONE NUMBER

PHONE NUMBER

DID THE EMPLOYEE VIOLATE ANY SAFETY PROCEDURES?

CIRCLE ONE: YES NO

EXPLAIN BELOW, ANY ACTION TAKEN TO PREVENT THIS FROM OCCURRING AGAIN

DATE

SIGNATURE OF REPORTING SUPERVISOR

Injured Employee's Name :_____

Employer:_____

WITNESS STATEMENT

Witness Name:_____Age_____, Phone #_____

Witness Complete Address:_____

Witness Employer Name, Address & Phone:_____

_____

If I should move or change my address, I can be located through:_____

Who resides at:_____, _____, TX_____

Name of injured employee: _____Date of Accident:_____19___

Time of Accident:_____Place where accident occurred:_____ Classroom _____ Hall _____Cafeteria

Other Location_____

Please explain fully what you know about this accident:_____

_____

Did you actually see this accident happen?_____If not, how did you learn about it? _____

_____

Describe Injury (part of body affected):_____

Did this employee ever talk to you about getting hurt on the job?_____

If so, how soon after the accident did this conversation take place?_____

Do you know of any other injury, accident or illness that this employee has had?_____

If so, explain: _____

Has this employee worked since the alleged date of accident? _____

If so, did he appear able to work as hard as before the accident?_____

If not, explain: _____

_____

How long have you known this employee?_____Are you related to this employee?_____

If so, what is your relationship?_____

Please give the name and addresses of any other persons who might know anything about this accident:

a._____

b._____

c._____

d._____

Witness Signature _____

Date_____

(USE OTHER SIDE IF MORE SPACE IS NEEDED)

RETURN THIS FORM TO SUPERVISOR WITHIN 24 HOURS OF THE ACCIDENT

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Also, more information is available on the Internet at: **www.oiec.state.tx.us <http://www.oiec.state.tx.us>.**

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division of Workers' Compensation is available on the Internet at: **<http://www.tdi.state.tx.us/wc/indexwc.html>.**

Your Rights in the Texas Workers' Compensation System:

1. **You may have the right to receive benefits.**

You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:

- You were intoxicated at the time of the injury;
- You injured yourself on purpose or while trying to injure someone else;
- You were injured by another person for personal reasons;
- You were injured by an act of God;
- Your injury occurred during horseplay; or
- Your injury occurred while voluntarily participating in an off-duty recreational, social, or athletic activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.**

3. **Choosing a treating doctor:**
   - If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list.
   - If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
   - If you are employed by a political subdivision (e.g. city, county, school district), you must follow its rules for choosing a treating doctor.

It is important to follow all the rules in the workers' compensation system. If you do not follow these rules, you may be held responsible for payment of medical bills.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**

Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**

An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of

workers' compensation and provide free assistance to injured employees who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

7. You have the right for your claim information to be kept confidential.

In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.

You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.

2. You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).

If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the TDI network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at <http://www.tdi.state.tx.us/consumer/complfrm.html#wc>

3. If you worked for a political subdivision (e.g. city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment. Your employer should be able to provide you with the information you will need in order to determine which health care provider can treat you for your workplace injury.

4. You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.

5. You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. You have one year to send the form after you were injured or first knew that your illness might be work related.

Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation. Call 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

6. You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.

7. You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:

- **You stop working because of your injury;**
- **You start working; or**
- **You are offered a job.**