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

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

Taylor Lunsford
Coordinator of Benefits and Risk Management
taylor.lunsford@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 1-28, box 39, sign and date in box 52.

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 (taylor.lunsford@sfisd.org), keep a copy for your records, and send originals in inter office mail.

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)	2. Address (street or PO box, city, state, ZIP code)		
3. Phone number	4. Email address	5. Social Security number (XXX-XX-XXXX)	6. Date of birth (mm/dd/yyyy)
7. Marital status	8. Sex ☐ Female ☐ Male ☐ Other		
9. Spouse's name (first, middle, last)		10. Number of dependent children	
11. Does the employee speak English? ☐ Yes ☐ No If no, specify language			
12. Doctor's name (first, last)	13. Doctor's mailing address (street or PO box, city, state, ZIP code)		

Part 2: Injury information

14. Date of injury or illness (mm/dd/yyyy)	15. Time of injury : ☐ a.m. or ☐ p.m.	16. First day absent from work (mm/dd/yyyy)
17. Supervisor's name (first, last)		18. Date injury reported (mm/dd/yyyy)
19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		20. Body parts affected
21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)		
22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)		
23. Was the employee doing their regular job? ☐ Yes ☐ No		
24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)		
25. List all witnesses (first, last names)		

26. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

27. Return-to-work date (mm/dd/yyyy) ☐ Actual date or ☐ Expected date	**28. Did the employee die?** ☐ Yes ☐ No If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)		**30. Occupation of injured employee**
31. Length of service in current position Years Months		**32. Length of service in current occupation** Years Months
33. Employee payroll classification code		**34. Was the employee hired or recruited in Texas?** ☐ Yes ☐ No
35. Rate of pay at this job $ Hourly $ Weekly	**36. Full work week is** Hours Days	**37. Last paycheck was** $ for Hours or Days

38. Is the employee an owner, partner, or corporate officer? ☐ Yes ☑ No

Part 4: Employer information

39. Name and title of person completing form (first, middle, last, title)	**40. Business name** SANTA FE ISD	
41. Business mailing address (street or PO box, city, state, ZIP code) P.O. BOX 370, SANTA FE, TX, 77510	**42. Phone number**	**43. Email address**
44. Business location (if different from mailing address) N/A	**45. Federal employer identification number** 74-6000028	
46. Primary North American Industry Classification System (NAICS) code (six digits)	**47. Specific NAICS code** (six digits)	**48. Texas comptroller taxpayer number**
49. Workers' compensation insurance carrier DEEP EAST TEXAS / ATHENS	**50. Policy number**	

51. Did you request accident prevention services in the past 12 months? ☐ Yes ☑ No

If yes, did you receive them? ☐ Yes ☑ No

Part 5: Certification

52. Certify with your signature:

I certify the information in this form is true and correct.

Signature_____ **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: Taylor Lunsford Title: Coordinator of Benefits and Risk Management

Phone: 409-925-9024 Date: _____

Form may be downloaded from www.wellnowhealth.net

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Dickinson, Texas 77539
Phone: 409.572.2535
Fax: 409.572.2480
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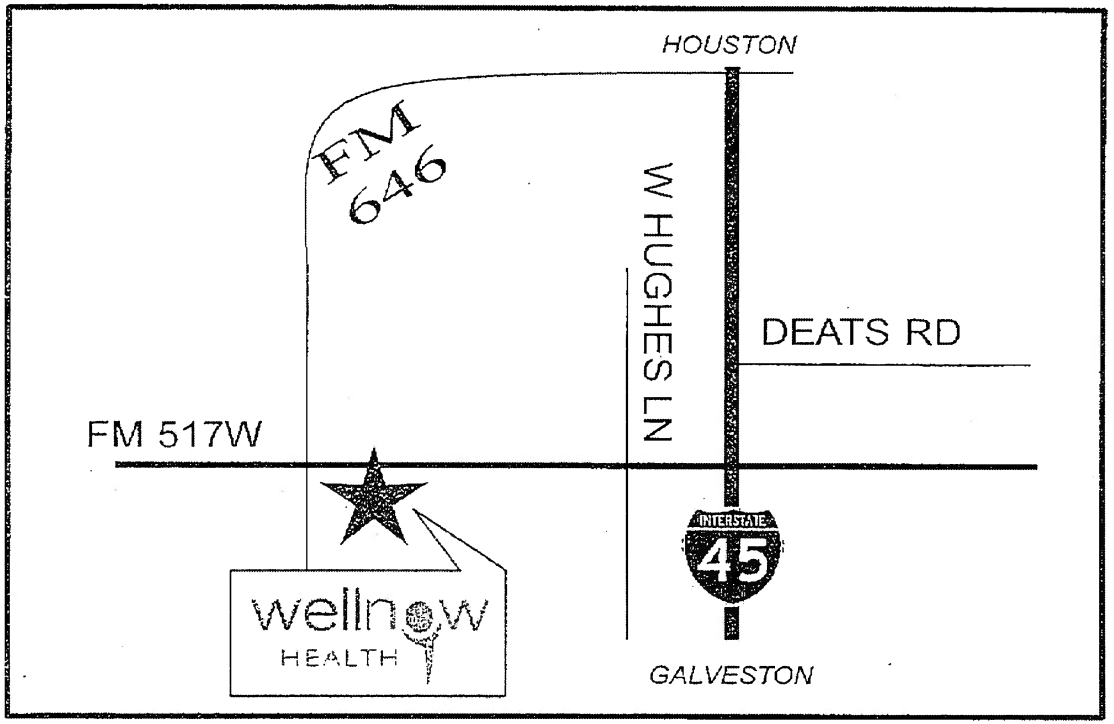

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Employee Election / Leave Benefit

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