

Postings

- All postings must be placed in Human Resources (if there is an office) and in each building to ensure all employees have access to the information.
- Postings must be in English and Spanish.
- Do not alter the content or size of any posting.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [_____] has workers' compensation insurance coverage from [_____] protect you in the event of work-related injury or illness. This coverage is effective from [_____].

Name of Employer

Name of commercial insurance company

Effective date of policy

Any injuries or illnesses which occur on or after that will be handled by [_____]. An employee or a person acting on the employee's behalf must notify the employer of an injury or illness not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an illness, unless the Division determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employer are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [_____] tiene cobertura
Nombre del empleador

de seguros de compensación para trabajadores con [_____]
Nombre de la compañía de seguros

para protegerlo en caso de una lesión o enfermedad relacionada con su trabajo. Esta cobertura está vigente desde

el [_____]. Cualquier lesión o enfermedad,
Fecha en que entra en vigencia la póliza

que ocurra en o a partir de esta fecha será manejada por [_____].
Nombre de la compañía de seguros

El empleado o la persona que lo representa debe notificar al empleador cuando el empleado sufre una lesión o enfermedad en el trabajo a no más tardar de treinta (30) días después de que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad, al menos que la División determine que existe un buen motivo para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador está obligado a proporcionarle información acerca de la cobertura de seguro de compensación, por escrito cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO:

La División le proporciona información gratuita sobre como someter un reclamo de compensación para trabajadores. El personal de la División le explicará cuales son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores de Texas y le asistirá para resolver disputas relacionadas con su reclamo. Usted puede obtener este tipo de asistencia comunicándose con la oficina local de la División al teléfono 1-800-252-7031.

LÍNEA PARA REPORTAR CONDICIONES INSEGURAS:

La División ha establecido una línea gratuita telefónica que está en servicio las 24 horas del día, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen al empleado o empleada porque el o ella, de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

EMPLEADORES CON COBERTURA:

Según el Reglamento 110.101(e)(1), el Aviso 6 del Departamento de Seguros de Texas, División de Compensación para Trabajadores, requiere que usted informe a sus empleados acerca de que tiene cobertura de seguros de compensación para trabajadores por medio de una compañía de seguros comercial y debe informar también a los empleados acerca de la línea gratuita de información de la División de Compensación para Trabajadores para obtener información adicional acerca de sus derechos de compensación para trabajadores.

Avisos en Inglés, Español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista del público y:

- (1) Mostrar muy a la vista en un lugar de la oficina de personal del empleador, si es que la hay;
- (2) Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
- (3) El título debe ser impreso en tamaño 30, letra negrita de punto, el tema debe ser impreso en tamaño 20, con letra negrita de punto, y el texto, por lo menos en tamaño 19 punto tipo normal.
- (4) Debe contener las palabras exactas como se ha señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requerimientos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la ley y reglamentos de la División.

NO MOSTRAR ESTE LADO



OFFICE OF INJURED EMPLOYEE COUNSEL

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is a state agency that is responsible for assisting injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-EZE-OIEC (1-866-393-6432). More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.state.tx.us).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN?

An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

If you have a proceeding scheduled before the Texas Department of Insurance, Division of Workers' Compensation, an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with your appeal and response to insurance carrier appeals.



LA OFICINA DE ASESORÍA PÚBLICA **PARA EL EMPLEADO LESIONADO**

Como empleado lesionado en Texas, usted tiene el derecho de recibir ayuda gratis por parte de La Oficina de Asesoría Pública para el Empleado Lesionado (OIEC, por sus siglas en inglés) la cual es una agencia estatal que ayuda a empleados lesionados que tienen un reclamo en el sistema de compensación para trabajadores.

Usted puede llamar a nuestro número de teléfono gratuito al 1-866-EZE-OIEC (1-866-393-6432) Para mayor información sobre OIEC y su programa del Ombudsman, por favor visite nuestra página de Internet www.oiec.state.tx.us.

PROGRAMA DEL OMBUDSMAN

¿QUÉ ES UN OMBUDSMAN?

Un ombudsman es un empleado de OIEC que puede ayudarlo si usted tiene alguna disputa con el seguro de compensación de su empleador. La ayuda que presta el ombudsman es gratis. Cada ombudsman tiene licencia de ajustador y un entrenamiento comprensivo y completo designado específicamente para ayudarlo con su disputa.

Si usted ya tiene un procedimiento fijado con el Departamento de Seguros de Texas, División de Compensación para Trabajadores un ombudsman puede:

- Ayudarlo a prepararse para el procedimiento (una Conferencia para Revisión de Beneficios o una Audiencia para Disputar Beneficios);
- Asistir al procedimiento con usted y comunicarse con la División en su nombre; y
- Además puede ayudarlo a apelar una decisión y responder a apelaciones hechas por parte de la compañía de seguros.



傷殘職工委員會辦公室

作為一名德克薩斯州的傷殘職工，你有權從傷殘職工委員會辦公室（OIEC）獲得無償援助。OIEC 是一家州立機構，負責協助傷殘職工進行符合職工賠償制度的索賠活動。

你可以撥打 OIEC 的免費電話聯繫，電話號碼是：1-866-EZE-OIEC（1-866-393-6432）。登陸該機構的網站（www.oiec.state.tx.us），可獲得更多有關 OIEC 及其“巡視官計畫”的資訊。

巡視官計畫

什麼是巡視官？

巡視官就是在你與你的職工保險投保公司發生糾紛時為你提供幫助的 OIEC 員工，他所提供的幫助是無償的。每個巡視官都持有《職工賠償調解員執照》，並且修滿了專門為協助你們處理糾紛而設計的所有的綜合培訓專案。

如果你已經與德州保險部職工賠償處確定好了訴訟的時間，那麼巡視官可以：

- 幫助你進行訴訟準備階段的工作（保險費評估會議和/或案件辯論審理）
- 與你共同出席訴訟並代表你進行溝通
- 協助你辦理上訴，並回應保險公司的上訴



VĂN PHÒNG LUẬT SƯ BÀO CHỮA CHO NHÂN VIÊN BI THƯƠNG TÍCH

Với tư cách là nhân viên bị thương tích tại tiểu bang Texas, quý vị có quyền được Văn Phòng Luật Sư Bào Chữa cho Nhân Viên Bị Thương Tích (Office of Injured Employee Counsel – OIEC) trợ giúp miễn phí. OIEC là một cơ quan tiểu bang, có nhiệm vụ giúp đỡ các nhân viên bị thương tích nộp đơn yêu cầu bồi thường tai nạn lao động.

Quý vị có thể liên lạc với OIEC tại số điện thoại miễn phí: 1-866-EZE-OIEC (1-866-393-6432). Quý vị cũng có thể tìm hiểu thêm về OIEC và Chương Trình Điều Tra Khiếu Nại của cơ quan này tại trang mạng điện toán (www.oiec.state.tx.us).

CHƯƠNG TRÌNH ĐIỀU TRA KHIẾU NẠI

VIÊN CHỨC ĐIỀU TRA KHIẾU NẠI LÀ AI?

Viên Chức Điều Tra Khiếu Nại là nhân viên của OIEC, là người có thể giúp quý vị trong trường hợp có tranh chấp với hãng bảo hiểm của hãng sở. Viên Chức Điều Tra Khiếu Nại cung cấp dịch vụ trợ giúp miễn phí. Mỗi Viên Chức Điều Tra Khiếu Nại đều có giấy phép hành nghề chuyên gia xác định phạm vi bảo hiểm bồi thường tai nạn lao động và đã hoàn tất chương trình huấn luyện toàn diện chuyên về giải quyết tranh chấp.

Nếu quý vị có một buổi hẹn tố tụng với Bộ Bảo Hiểm Texas (Texas Department of Insurance), Ban Bồi Thường Tai Nạn Lao Động (Division of Workers' Compensation), Viên Chức Điều Tra Khiếu Nại có thể:

- Giúp quý vị chuẩn bị cho buổi tố tụng đó (Buổi Họp Duyệt Xét Quyền Lợi và/hoặc Buổi Điều Trần về Khiếu Nại);
- Tham dự buổi tố tụng cùng quý vị và liên lạc thay cho quý vị; và
- Giúp quý vị hoàn thành thủ tục kháng cáo và trả lời kháng cáo của hãng bảo hiểm.

**TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE
DISEASES AND ELIGIBILITY FOR WORKERS'
COMPENSATION BENEFITS**

TO: Law Enforcement Officers, Fire Fighters, Emergency Medical Service Employees, Paramedics, and Correctional Officers -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, AN EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO A REPORTABLE DISEASE, INCLUDING HIV INFECTION, MUST BE TESTED FOR THE DISEASE NOT LATER THAN THE 10TH DAY AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A SWORN AFFIDAVIT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF THE DISEASE. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of Health. Exposure criteria and testing protocol must conform to Texas Department of Health requirements.

TO: All State Employees -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, A STATE EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, MUST BE TESTED FOR HIV WITHIN 10 DAYS AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A WRITTEN STATEMENT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF HIV INFECTION. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

FOR ADDITIONAL INFORMATION: TALK TO YOUR EMPLOYER OR CALL THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION AT 1-800-372-7713. ALSO, CONTACT THE TEXAS DEPARTMENT OF HEALTH (TDH) TO ENSURE FULL COMPLIANCE WITH THE HEALTH AND SAFETY CODE AND TDH RULES.

**DEPARTAMENTO DE SEGUROS DE TEXAS
DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES
AVISO ACERCA DE CIERTAS ENFERMEDADES CONTAGIOSAS
RELACIONADAS AL TRABAJO Y ELIGIBILIDAD PARA BENEFICIOS DE
COMPENSACIÓN PARA TRABAJADORES**

PARA: Oficiales de la Ley, Bomberos, Empleados del Servicio de Ambulancia, Paramédicos y Oficiales del Departamento de Correcciones -

PARA CALIFICAR PARA BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO QUE RECLAMA QUE POSIBLEMENTE FUE EXPUESTO A UNA ENFERMEDAD QUE DEBE SER REPORTADA, INCLUYENDO INFECCIÓN AL SIDA, DEBERA SER EXAMINADO NO MAS TARDE DEL 10^{mo} DÍA DESPUES DE QUE HAYA SIDO EXPUESTO Y DEBERA PROPORCIONAR AL EMPRESARIO DOCUMENTACIÓN DEL EXAMÉN Y UNA COPIA NOTARIZADA CON LA FECHA Y CIRCUMSTANCIA DE LA CAUSA A LA CUAL FUE EXPUESTO. EL RESULTADO DEL EXAMÉN DEBE INDICAR LA AUSCENCIA DE LA ENFERMEDAD. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMÉN.

Las enfermedades reportadas son enfermedades contagiosas y condiciones de la salud que se requieren reportar al Departamento de Salud de Tejas. El criterio para estar expuesto y el protocolo del examen debe cumplir los requisitos del Departamento de Salud de Tejas.

PARA: Todo Empleado Estatal -

PARA CALIFICAR PARA BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO ESTATAL QUE RECLAMA QUE POSIBLEMENTE HAYA SIDO EXPUESTO AL SIDA RELACIONADO CON EN TRABAJO, DEBERA SER EXAMINADO PARA EL SIDA DENTRO DE 10 DIAS DESPUES DE QUE FUE EXPUESTO Y DEBERA PROPORCIONAR AL EMPRESARIO DOCUMENTACIÓN DEL EXAMÉN Y UNA CARTA CON LA FECHA Y CIRCUMSTANCIA DE LA CAUSA A LA CUAL FUE EXPUESTO. EL RESULTADO DEL EXAMÉN DEBE INDICAR LA AUSCENCIA DE INFECCIÓN AL SIDA. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMÉN.

PARA INFORMACIÓN ADICIONAL: HABLE CON SU EMPRESARIO O LLAME A LA DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES AL 1-800-372-7713. TAMBIÉN, COMUNIQUESE CON EL DEPARTAMENTO DE SALUD DE TEJAS (TDH) PARA ASEGURAR QUE LOS REQUISITOS EN LAS REGLAS DE SALUD Y SEGURIDAD DEL Y TDH HAYAN SIDO CUMPLIDOS.

NOTICE OF POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE REQUIREMENTS FOR WORK RELATED INJURIES

Dear Employee:

Your employer has chosen the Political Subdivision Workers' Compensation Alliance (the Alliance) to manage the health care and treatment you may receive if you are injured at work. The Alliance includes a list of health care providers who are trained in treating work related injuries and getting people back to work safely.

When you are injured at work....

Tell your supervisor or employer immediately. For emergencies, you may go to the nearest emergency room. Otherwise, you must choose a treating doctor from the list on the web site below. Your employer will assist with any questions about how to obtain treatment. You may also contact your adjuster at the TASB Risk Management Fund (the Fund) for any questions about treatment for a work related injury. The Fund is your employer's workers' compensation coverage provider. They work with your employer to ensure you receive timely health care. The goal is to return you to work as soon as it is safe to do so.

When you are injured, you may locate a medical provider on line at www.pswca.org.

You may contact your adjuster at the TASB Risk Management Fund at 800- 482-7276.

NOTICE OF POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE REQUIREMENTS FOR WORK RELATED INJURIES

AVISO DEL POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE PARA LASTIMADURAS OCURRIENDO EN EL TRABAJO

Estimado Empleado:

Su compañía de empleo escogió la Political Subdivision Workers' Compensation Alliance (PSWCA) para dirigir sus tratamientos médicos si se lastima en el trabajo. La organización PSWCA incluye una lista de médicos que están entrenados y preparados para tratar empleados que han sido lastimados en el trabajo.

Si se lastima en el trabajo...

Inmediatamente avisele a su supervisor o a la persona que lo emplea. En un caso de emergencia, Usted puede ir al hospital más cerca. En otros casos, visite la lista de médicos aprobados por PSWCA localizados en el Internet (www.pswca.org). Su compañía de empleo también le puede asistir en contestarle preguntas sobre tratamientos médicos. El ajustador de Texas Association of School Boards – Risk Management Fund (TASB) también le puede ayudar en contestarle sus preguntas relacionadas a su tratamiento médico. La compañía TASB también se comunica con su empleador para asegurar que Usted reciba la ayuda médica propia. El objetivo de TASB y su empleador es regresarlo a su trabajo en una manera segura y en buena salud.

Cuando ha sido lastimado puede localizar un médico en el Internet: www.pswca.org.

Puede hablarle a su ajustador de TASB al número siguiente: 800-482-7276.

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

Call the Division of Workers' Compensation at 512-804-4345 to receive information on the legal requirement for coverage, to verify whether your employer has provided the required coverage, or to report an employer's failure to provide coverage.

TO THE EMPLOYER/CONTRACTOR:

Pursuant to Workers' Compensation Rule 110.110 (d)(7), a contractor engaged in a building or construction project for a government entity is required to post a notice on each project site informing all persons providing services on the project that they are required to be covered by workers' compensation insurance. The notice required by this does not satisfy other posting requirements imposed by the Texas Workers' Compensation Act or other Workers' Compensation Rules. This notice must:

- (1) be posted in English, Spanish and any other language common to the employer's employee population;
- (2) be displayed on each project site;
- (3) state how a person may verify current coverage and report failure to provide coverage;
- (4) be printed with a title in at least 30-point bold type and text in at least 19-point normal type; and
- (5) contain the exact words as prescribed in Rule 110.110 (d)(7)

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Act and Workers' Compensation Rules. The violator may be subject to administrative penalties.

COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

La ley requiere que cada persona que trabaja en este lugar o que proporciona servicios relacionados con este proyecto de construcción debe estar cubierta por un seguro de compensación para trabajadores. Esto incluye a personas que proporcionan, transportan, o entregan equipo o materiales, o que proporcionan mano de obra, u otros servicios relacionados con este proyecto, sin importar la identidad del empleador o el estado como empleado.

Comuníquese con la División de Compensación para Trabajadores al teléfono 512-804-4345 para recibir información referente a los requerimientos legales de cobertura, para verificar si su empleador ha proporcionado la cobertura requerida, o para reportar a un empleador que no proporciona cobertura.

AL EMPLEADOR / CONTRATISTA:

Según el Reglamento de Compensación para Trabajadores 110.110 (d)(7), requiere que un contratista que está involucrado en el proyecto de construcción de un edificio de entidad gubernamental muestre este aviso en cada lugar donde se lleva a cabo el proyecto para así informar a todas las personas que proporcionan servicios en el proyecto que se les debe proporcionar un seguro de compensación para trabajadores. El aviso presentado aquí no satisface otros avisos de requerimientos impuestos por la Ley de Compensación para Trabajadores de Texas u otros Reglamentos de Compensación para Trabajadores. Este aviso debe:

- (1) ser mostrado en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador;
- (2) ser mostrado en cada área de trabajo en el proyecto;
- (3) explicar como una persona puede verificar la cobertura actual del empleador y como reportar si el empleador no ofrece cobertura;
- (4) ser impreso con un título en por lo menos tamaño 30, con letra negrita de punto, y el texto en por lo menos tamaño 19 en punto tipo normal; y
- (5) contener las palabras exactas como se ha señalado en el Reglamento 110.110 (d)(7).

El aviso que se muestra al reverso de esta página cumple con los requisitos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la Ley y Reglamentos de Compensación para Trabajadores. El infractor puede estar sujeto a penalidades administrativas.

Forms



WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE				
		JURISDICTION		JURISDICTION CLAIM NUMBER						
		INSURED REPORT NUMBER								
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #				
INDUSTRY CODE		EMPLOYER FEIN						PHONE #		
CARRIER/CLAIMS ADMINISTRATOR										
CARRIER (NAME, ADDRESS, & PHONE #)			POLICY PERIOD		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)					
			TO							
			CHECK IF APPROPRIATE							
			<input type="checkbox"/> SELF INSURANCE							
CARRIER FEIN		POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN					
AGENT NAME & CODE NUMBER										
EMPLOYEE/WAGE										
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE		
ADDRESS (INCL ZIP)			SEX		MARITAL STATUS		OCCUPATION/JOB TITLE			
			<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS			
PHONE			# OF DEPENDENTS				NCCI CLASS CODE			
RATE PER:		<input type="checkbox"/> DAY WEEK	<input type="checkbox"/> MONTH OTHER:	DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	
		<input type="checkbox"/> YES	<input type="checkbox"/> NO					<input type="checkbox"/> YES	<input type="checkbox"/> NO	
OCCURRENCE/TREATMENT										
TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE () CANNOT BE DETERMINED		<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE		DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED				
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE				
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED						
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL								CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			<input type="checkbox"/> YES	<input type="checkbox"/> NO		
				WERE THEY USED?			<input type="checkbox"/> YES	<input type="checkbox"/> NO		
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
							0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
OTHER										
WITNESSES (NAME & PHONE #)										
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER		

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On	Strike	Unkno	wn	Volunteer
Part-Time	Disabled		Apprenticeship		Full-Time Seasonal
Not Employed	Retired	Apprenticeship			Part-Time Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.



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.

**SAMPLE FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(OFFSET)**

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. During the first seven days my leave will be used in full-day increments. I understand that once I begin to receive workers' compensation weekly income benefits my leave will be used in partial-day increments to supplement workers' compensation income benefits.
- I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from _____ 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 income 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: _____



**SAMPLE FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION
(NO OFFSET)**

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 _____ 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 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

<i>For Claims Reporting Purposes Only:</i>	
<p><i>For all employees:</i> Amount of leave paid to employee: \$ _____ Daily rate: \$ _____ Period of payment: from ___/___/___ through ___/___/___ for _____ days or _____ weeks</p>	<p><i>For hourly employees only:</i> Hourly rate: \$ _____ Number of hours paid: _____</p>



EMPLOYEE ACKNOWLEDGMENT 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 or 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 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 www.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.

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

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 tartar.
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 opcion, puedo escoger solamente de la lista de doctores aprovados por la Alliance. Una tercera opcion, tendre que recibir aprobación de mi ajustador antes de cambiar.

Signature (Firma): _____ Date (Fecha): ____/____/____

Printed Name (Nombre en imprenta): _____

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

Employer (Nombre de empleo): _____

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

Progressive Medical's First Fill® Program



When an injured party needs medication immediately, the First Fill option allows you to authorize these prescriptions and get them on the road to recovery.

**Questions?
(888) 908-6337**

Instructions for the Company

- Fill in the ID/Auth# as instructed on the First Fill card below along with the name, date of birth and gender.
- Instruct the injured party to take the First Fill card and their prescription to the pharmacy.
- Report the claim to the appropriate insurance company/TPA.

Note: If additional, ongoing medication is required, the claims professional should contact Progressive Medical to utilize our Retail Drug Card program. If additional First Fill cards are needed, or if you have any questions regarding the use of this program, please contact Progressive Medical at 1-888-908-MEDS and ask for the Pharmacy Services Coordinator.


Instructions for the Injured Party

**Questions?
(888) 908-6337**

- Report your injury to the appropriate personnel.
- At the bottom of this form is a First Fill card that will enable you to obtain the "initial" prescriptions needed upon injury with no out-of-pocket expense.
- A sample list of "Participating Pharmacy Chains" that accept this First Fill card is included on the back.
- Present your First Fill card and your prescription to the pharmacist.
- This card is for a one time use to receive your medications per your employer/insurance company. Use of this card is restricted to your allowed condition.
- If you have any questions, call Progressive Medical toll-free at 1-888-908-MEDS. Our Client Services Specialists are available 24-hours a day to take care of your needs.

PLEASE NOTE: IF YOUR WORKERS' COMPENSATION CLAIM IS ACCEPTED, YOU WILL RECEIVE A RETAIL DRUG CARD IN THE MAIL. PRESENT THAT CARD WHEN FILLING SUBSEQUENT INJURY-RELATED PRESCRIPTIONS.

FIRST FILL® CARD	
BIN#: Restat 600471	_____
Company Name: Texas Association of School Boards	_____
Group/Plan#: E127	_____
Person Code: 00 (zero, zero)	_____
ID/Auth#: _____	_____
SSN (9 digits, no dashes) Date (6 digits, no dashes) E.g. if the SSN is 000-00-0000 and today's date is May 21, 2007, the ID/Auth# is 000000000052107.	
Injured Party's Name: _____	_____
Date of Birth: _____	Gender: _____

1-888-908-MEDS	
For claim submission issues, prior authorization or claim rejections, please contact Progressive Medical, Inc. at 1-888-908-6337.	
Pharmacist: If you experience any problems, please call 1-888-908-6337.	
<small>Disclaimer: It is important to note the issue will be determined by the claims department and the confirmation of this treatment/service request is in no way intended as an endorsement of the treatment/service request, nor is it intended to interfere with the provider from his or her duty to adhere to any applicable practice standards.</small>	



Cuando una persona lesionada necesita medicamentos de inmediato, la opción con la tarjeta First Fill (Surtir primero) le permite autorizar estas recetas y ayudarlo a recuperarse.

¿Preguntas?
(888) 908-6337

Instrucciones para la compañía

- Anote el número de identificación/autorización en la tarjeta First Fill al verso junto con el nombre, la fecha de nacimiento y el sexo.
- Indique a la persona lesionada que lleve la tarjeta First Fill y su receta a la farmacia.
- Reporte la reclamación a la aseguradora/TPA apropiada.

Nota: Si se requiere recibir medicamentos adicionales continuamente, el profesional de reclamaciones debe ponerse en contacto con Progressive Medical para utilizar nuestro programa de Tarjeta de Medicamentos al por Menor. Si se necesitan tarjetas First Fill adicionales, o si tiene alguna pregunta sobre cómo usar este programa, llame a Progressive Medical al 1-888-908-MEDS y pida hablar con el Coordinador de Farmaceuta.

Instrucciones para el lesionado:

¿Preguntas?
(888) 908-6337

- Reporte la lesión al personal apropiado.
- Al verso aparece una tarjeta First Fill que le permitirá obtener los medicamentos "iniciales" necesarios para la lesión sin costo de su parte.
- Recibirá una tarjeta First Fill para usar para recibir los medicamentos aprobados.
- Presente su tarjeta First Fill y su receta al farmaceuta.
- Recibirá los medicamentos sin costo alguno para usted.
- Si tiene alguna pregunta, llame a Progressive Medical al (888) 908-6337. Nuestros coordinadores están disponibles las 24-horas al día.

NOTA: SI SE ACEPTA SU RECLAMO DE COMPENSACIÓN DEL SEGURO OBRERO, RECIBIRÁ POR CORREO UNA TARJETA DE FARMACIA AL POR MENOR. PRESENTE ESA TARJETA AL SURTIR RECETAS SUBSECUENTES RELACIONADAS CON EL TRABAJO.

Sample Listing of Participating Pharmacies

The following is a sampling of 64,000 participating pharmacies accessible through our program:

Albertsons	Longs Drug Stores	Duane Reade
Safeway	Giant Eagle Pharmacy	Winn Dixie Pharmacy
Meijer Pharmacy	Publix Pharmacy	CVS Pharmacy
Walgreens	Rite Aid Pharmacy	Eckerd Drugs
K-Mart	Fred Meyer	Target Pharmacy
Tops Markets	Medicine Shoppe	Wal-Mart Pharmacy

For additional pharmacies within your area, call Progressive Medical's Client Services department at 1-888-908-6337 or visit our Web site at www.progressive-medical.com. Go to the Workers' Compensation tab and click on Total Pharmacy Management then select Pharmacy Locator. Enter your city, state or zip code and click on "Locate." You will see a listing of pharmacies located within your area.



Progressive Medical, Inc. están trabajado juntos para provee al trabajador accidentado con el programa de tarjeta de medicamento llamada First Fill®.

En la parte baja de este formulario se encuentra la tarjeta de medicamento que permitirá al tabajador obtener el medicamento inicial después del accidente, con poco ó sin ningún costo de su parte. Una lista de Cadenas farmaceuticas, que participan con este programa, ha sido incluida al reverso de esta tarjeta.

Instrucciones para la compañía sobre el uso de la tarjeta First Fill®

- Accidente ocurre y empleado reporta el accidente al personal apropiado
- Provea el nombre del empleado, número social, fecha de accidente y fecha de nacimiento.
- Despues de explicarle el uso de la tarjeta al empleado, por favor de le este documento.
- Instruya al empleado que presente esta tarjeta junto con la prescripción a la farmacia. (Refiera la lista de farmacias proveida con la tarjeta)
- Reporte el accidente a la compañía de seguro apropiada.
- La farmacia procesara los medicamentos y el cobro será enviado a Progressive Medical.
- La tarjeta First Fill® unicamente puede ser usada una sola vez.

Por favor, de suma importancia:

Si medicamentos adicionales sean necesarios, la persona encargada del caso en la compañía de seguro tendrá que contactar Progressive Medical para utilizar el programa de venta al menor de medicamentos.

Si más tarjetas de First Fill® son necesarias o si tiene preguntas en relación del programa, por favor contacte Progressive Medical al 1-888-908-MEDS(6337) y pregunte por el coordinador de First Fill®.

Instrucciones para el empleado accidentado acerca del use de tarjeta First Fill®:

- Este formulario será utilizado una sola vez para cubrir medicamento(s) autorizados por su compañía de seguro.
- El uso de esta tarjeta es restringida unicamente para su compensación de trabajo.
- Para recibir los beneficios, presente esta tarjeta a una de las farmacias participantes (Una lista de farmacias a sido provista en la parte posterior de este formulario). Debajo de este formulario encontrará la tarjeta First Fill® que le permitirá obtener los primeros medicamentos necesario por su accidente de trabajo con un mínimo o sin ningun costo alguno de su parte.
- Si tiene alguna pregunta, llame a Progressive Medical al 1-888-908-MEDS (6337). Nuestros coordinadores están disponibles las 24 horas al día.

250 Progressive Way
Westerville, Ohio 43082
(800) 777-3574 (614) 794-3300
Fax (614) 794-9582
e-mail: progressive@progressive-medical.com
www.progressive-medical.com



CLAIM # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months?	yes <input type="checkbox"/> DATE _____ no <input type="checkbox"/>
7. Has the employer requested RTW training from DWC or the insurance carrier?	yes <input type="checkbox"/> no <input type="checkbox"/>
8. Has the insurance carrier provided accident prevention services in the past 12 months?	yes <input type="checkbox"/> DATE _____ no <input type="checkbox"/>
9. Has the employer requested accident prevention services from the insurance carrier?	yes <input type="checkbox"/> no <input type="checkbox"/>

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/> a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
<input type="checkbox"/> b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
<input type="checkbox"/> c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
<input type="checkbox"/> d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated, or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____ 19a. Reason for resignation/termination _____ 19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury	21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____ hourly Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same as pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage	

This form to be filed with: *The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.*

22. To the best of my knowledge, the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
 Submitted by: Employer Injured Worker (if no longer working for the employer where injury occurred.)

 Signature and Title of person completing this form

 Date





POST INJURY EARNINGS WORKSHEET

Before completing this worksheet, please read the “*Post Injury Earnings Reporting Instructions*” in the Downloads box at http://www.tasbrmf.org/wc/documents/pie_instructions2.pdf

Injured Worker:

Date of Injury:

Claim Number:

Social Security Number:

NOTE: Before reporting sick and/or annual leave, make sure the employee made an informed election to use the leave. If the election was not made, the payments are not considered PIE and do not need to be reported.

A sample employee election form is located at <http://www.tasbrmf.org/wc/dwc-6.aspx> Please provide the election form to your adjuster along with this worksheet and the DWC-6: Supplemental Report of Injury when reporting Post Injury Earnings (PIE).

Type of PIE	Amount Paid	Period of Payment	Number of
Weekly Amount of Sick Leave equivalent to preinjury rate of pay (employee elections only)	\$	through	week(s) day(s) month(s)
Weekly Amount of Annual Leave equivalent to preinjury rate of pay (employee elections only)	\$	through	week(s) day(s) month(s)
Weekly Amount of Modified Duty Wages (accepted or refused)	\$	through	week(s) day(s) month(s)
Weekly Amount of Employer Paid Employee Contributions (i.e., <u>employee's</u> portion of health insurance)	\$	through	week(s) day(s) month(s)
Weekly Amount of Salary Continuation (i.e., holiday pay)	\$	through	week(s) day(s) month(s)
Other Pecuniary Wages less than or equivalent to preinjury weekly rate of pay (i.e., extended leave or sick leave pool/bank) Specify “other” type here:	\$	through	week(s) day(s) month(s)

Employer Representative

Date

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
<p>The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about:</p> <ul style="list-style-type: none"> • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. <p>Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.</p>	<p>If you (the INJURED WORKER) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about:</p> <ul style="list-style-type: none"> • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. <p>This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.</p>
<p>The EMPLOYER must file this form:</p> <ul style="list-style-type: none"> • For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • During the time the injured worker is entitled to temporary income benefits (TIBs); and • Until the injured worker: <ul style="list-style-type: none"> ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer. 	<p>If you are employed by a new employer after the injury; and</p> <ul style="list-style-type: none"> • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are <i>not</i> receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.
<p>This report must be filed in the following situations within the timeframes indicated:</p> <ul style="list-style-type: none"> • 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury; • 3 days after the injured worker returns to work; • 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury; • 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury; • 10 days after the injured worker resigns or is terminated. <p>While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:</p> <ul style="list-style-type: none"> • If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time. • If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning. 	
<p>This form is to be filed by first class mail or personal delivery with:</p> <ul style="list-style-type: none"> • The insurance carrier, and • The injured worker. <p>This report is considered filed when personally delivered or postmarked.</p> <p>Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.</p>	<p>This form is to be filed by first class mail or personal delivery with:</p> <ul style="list-style-type: none"> • The insurance carrier. <p>This report is considered filed when personally delivered or postmarked.</p> <p>If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.</p> <p>Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.</p>

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



Send to workers' compensation carrier:

(name and fax number of carrier)



CLAIM# _____

CARRIER'S CLAIM # _____

- Initial
- Amended

EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS

The Texas Workers' Compensation Act and Commission rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW for a school district employee is computed based upon the wages earned in a week. "Wages earned in a week" are equal to the amount that would be deducted from an employee's salary if the employee were absent from work for one week and the employee did not have personal leave to compensate the employee for the lost wages from that week.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063 (c) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

- (A) the employee's eighth day of disability;
- (B) the date the employer is notified that the employee is entitled to income benefits;
- (C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes.

All applicable DWC rules can be found at www.tdi.state.tx.us/wc

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number:	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:
<input type="checkbox"/> The employee has not returned to work. OR <input type="checkbox"/> The employee returned to work on _____ <input type="checkbox"/> without restriction. OR <input type="checkbox"/> with restrictions and is earning wages of \$_____ per week/month (circle one).	I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Worker's Compensation Act and applicable rules; and the listed wages include all pecuniary wages and stipends as required by statute and rule and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.
NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC-6) to report changes in Work Status and Post-Injury Earnings.	Signature: _____ Date: _____

EMPLOYMENT STATUS

Does the employee work continuously through the calendar year for the school district (i.e. does the employee work in the summer?) The answer to this question is not affected by whether the employee is paid over a 12 month period or over a shorter period.

YES NO. If no, what were the dates and the number of days or months the employee was **scheduled to work** in the current school year? From ____/____/____ to ____/____/____ which requires the employee to work _____ days OR _____ months.

WRITTEN CONTRACT EMPLOYEE: an employee who has a written contract of employment with the school district that specifies amount that will be paid for completion of the contract and either the number of days the employee is required to work or the period of the contract.

If the employee is employed through a written contract, complete the "Written Contract Wage Information" and the "Annual Wage Information" sections on page 2.

EMPLOYEE WITHOUT A WRITTEN CONTRACT:

Salaried: an "at-will", "exempt" employee paid a set salary per month/year (generally personnel staff).

Hourly: an "at-will", "non-exempt" employee paid on an hourly basis (generally staff such as cafeteria workers, bus drivers, janitorial workers).

Daily: an "at will" employee employed and paid on a daily basis (generally substitute teachers).

Other: (specify)

If the employee is NOT employed through a written contract, complete the "Wage Information for Salaried, Hourly, Daily, and Other Non-Contract Employment" and the "Annual Wage Information" sections on page 2.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us/wc



Send to workers' compensation carrier:

 (Name and fax number of carrier)



CLAIM # _____
 CARRIER'S CLAIM # _____

Initial Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

- (A) the employee's eighth day of disability;
- (B) the date the employer is notified that the employee is entitled to income benefits;
- (C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number:	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:
<input type="checkbox"/> As of today's date, the employee is not back at work. OR <input type="checkbox"/> The employee returned to work on _____ and is working: <input type="checkbox"/> without restriction. OR <input type="checkbox"/> with restrictions and is earning wages of \$_____ per week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.	I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

<input type="checkbox"/> Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. <input type="checkbox"/> Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.	<input type="checkbox"/> Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period. <input type="checkbox"/> Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. <input type="checkbox"/> Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.	<input type="checkbox"/> Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. <input type="checkbox"/> Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training. <input type="checkbox"/> Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.
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SAME OR SIMILAR EMPLOYEE?

<p>The wage information on this form is for:</p> <input type="checkbox"/> The Injured Employee OR <input type="checkbox"/> A Similar Employee (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)	<p>If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.</p>
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NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.



WAGE INFORMATION INSTRUCTIONS

Employee Name:

Social Security #:

Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury**. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														
# HOURS WORKED:														TOTALS
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid to allow the employee to purchase the benefits.

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/Cleaning																		
Clothing/Uniforms																		
Lodging/Housing/																		
Food/Meals																		
Vehicle/Fuel																		
Other																		



PAGE 2 WAGE INFORMATION

Employee Name:

Social Security #:

Date of Injury:

WRITTEN CONTRACT WAGE INFORMATION

Total Gross Value of Written Contract (including stipends):

Number of Work Days in Written Contract:

OR

Number of Months in Written Contract:

WAGE INFORMATION FOR SALARIED, HOURLY, DAILY, & OTHER NON-CONTRACT EMPLOYMENT

- Report the Gross Pecuniary Wages **earned in the 13 weeks immediately prior to the date of injury**. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

- **Pecuniary Wages include all wages that are paid to the employee in the form of money**. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse travel expenses.

- If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer may not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

- If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

The wage information in this section is from: **the Injured Employee** OR **a Similar Employee** (If requested by the Commission, the employer shall identify the similar employee whose wages were provided.)

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

ANNUAL WAGE INFORMATION

-Indicate the Gross Pecuniary Wages **earned in the 12 months immediately prior to the date of injury**. Include all actual money earned and paid to the employee for time off for vacation leave, sick leave and holidays but not the market value of leave time earned but not used.

- If the employee did not work for your district for one of the months indicated below, insert the letters "NE" to indicate "not employed."

- If the employee did work for your district during the month, but did not earn any wages please insert a "0".

-When setting the 12 months, you may adjust the reporting period backward up to the month prior to the date of injury to line the months up with your natural pay cycle. **Do not report wages earned on or after the date of injury.** Weekly wages may be converted to monthly wages by multiplying the gross weekly wages amount by 4.34821.

MONTH #	1	2	3	4	5	6	7	8	9	10	11	12	
FROM DATE:													
TO DATE:													TOTAL
WAGES EARNED:													



EMPLOYER REQUIRED DWC FORMS QUICK REFERENCE

DWC Form	Description	Due Date	Required Recipient(s)
IA-1: First Report of Injury	This form is used to report a work related injury with more than one day of lost time and any occupational illness regardless of lost time	No later than 8 days after knowledge of a work related injury/illness or death	Insurance carrier, injured worker and representative (if any) - Remember to copy the injured worker with the Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System located on line at: http://www.tasbrmf.org/wc/claim.aspx
DWC-3: Employer's Wage Statement or DWC-3SD: Employer's Wage Statement for School Districts	This form is used to report an injured worker's wages.	No later than 30 days after the earliest of: a) the date the employer is notified that the employee is entitled to income benefits, or b) the date of the employee's death as a result of a compensable injury.	Insurance carrier, injured worker, and representative (if any)
DWC-6: Supplemental Report of Injury	This form is used to report work status and post injury earnings (PIE) such as sick leave. PIE Reporting Instructions can be viewed on our web site below under the Report a Claim link – File a Supplemental Report of Injury.	No later than 3 days after the injured worker returns to work or misses additional work after initially returning to work No later than 10 days after the employee has a change in earnings, resigns or is terminated	Insurance carrier, injured worker, and representative (if any)
DWC-156: Prospective Employment Authorization and Certification	This form is used to obtain recent workers' compensation claim information for an employment applicant	No later than 14 days after the date on which the application for employment is submitted	DWC
DWC-4: Employer's Contest of Compensability	This form is used to contest the claim after the insurance carrier has accepted liability	No later than 50 days after the date the insurance carrier received the first notice of injury	DWC
DWC-2: Employer's Report for Reimbursement of Voluntary Payment	This form is used to obtain reimbursement for temporary payment of income benefits and medical bills.	An employer who fails to timely file the report of injury or occupational disease waives the right to reimbursement.	Insurance Carrier

- ❖ To file the IA-1, DWC-3, DWC-3SD or DWC-6 on line with the Fund, go to <http://www.tasbrmf.org>, and click on the "Report a Claim" link
- ❖ A complete listing of all DWC forms is located on the DWC website @ <http://www.tdi.state.tx.us/wc/forms/index.html>

