KILLEEN ISD RISK MANAGEMENT

WORKERS' COMPENSATION

Verification of Receipt

I have received the following forms concerning my work-related injury/illness:

Please check (√) all that apply:

- ☐ **First Report of Injury/Illness**
- ☐ **Acknowledgment of Alliance**
- ☐ **Clinic Incident Report**

Are you seeking medical treatment?

- ○ **No, not at this time**
- ○ **Yes, please √ a treatment option listed below:**

Conveniently located Walk-In Facilities:

- ○ Freedom Urgent Care, Killeen
- ○ Freedom Urgent Care, Harker Heights
- ○ Elms Creek Family & Urgent Care, Killeen
- ○ Integrity Urgent Care, Copperas Cove
- ○ Integrity Urgent Care, Killeen *NEW*
- ○ AFC Urgent Care, Temple
- ○

Require an Appointment:

- ○ Baylor Scott & White Occupational Medicine Clinic, Temple
- ○ Advent Health FMC, Copperas Cove
- ○ Advent Health FMC, Lampasas

**** For a complete list of providers, please visit www.pswca.org***

I understand that if I have any questions concerning my work related injury, seek medical treatment or miss any time related to this claim I will contact my campus/department supervisor and the Risk Management Office at (254) 336-0068.

_____ _____

Printed Name Campus/Department

_____ _____

Signature Date

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Guidelines

District employees must report all work related injuries, illnesses and exposures to their immediate supervisor even if they do not go to the doctor.

The supervisor will immediately report the injury to the Risk Management Office for guidance. Initial first aid can be obtained from the school nurse when possible; however, injuries that exhibit loss of life or limb should be directed to the nearest hospital emergency room.

The supervisor should conduct an initial investigation using the employee and witness statement(s) in conjunction with the circumstances of the incident and provide the results to the Risk Management Office upon request.

The supervisor will fax the completed form to the Risk Management Office, 336-0091, and maintain the original of this report for record purposes.

As of July 1, 2008, Political Subdivisions as defined in Chapter 504 of Texas Labor Code have instituted requirements and procedures for seeking medical treatment for work related injuries. Killeen ISD's Workers' Compensation Insurance Carrier is a member of the Political Subdivision Workers' Compensation Alliance (PSWCA). Employees must seek medical attention from a contracted Alliance primary care physician for all treatment who will direct or refer the employee to any specialists as needed. **Employees who choose to seek medical treatment outside the Alliance's contracted providers may be responsible for all payments and may be denied workers' compensation benefits.** Please view the KISD PSWCA notice posted on your campus or departments bulletin board.

Employees must read and sign the PSWCA Employee Acknowledgement notice and submit it to the Risk Management office with the injury report.

The report will be reviewed by the Risk Management Office and submitted to the workers' compensation insurance carrier for appropriate case management.

Risk Management and the workers' compensation insurance carrier has the right to investigate or further inquire into all District related injuries or incidents.

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2, 7, 8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	Please provide an operational phone number where the employee can be reached.
Items 5, 15, 17, 26, 29:	Enter data in month, day, year format. Example: 08-13-54.
Item 13:	Enter your primary doctor's name
Item 18:	List nature of accident or exposure, e.g., fall from same level, cut, contusion, burn, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Fax the completed form to (254) 336-0091 or take it to the Risk Management Office.

Send the completed form to the Risk Management Office via fax or email:

(254) 336-0091

or

WorkersCompHR@killeenisd.org

CLAIM # _____

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ○ M ○

3. Employee ID Number

4. Phone Number

5. Date of Birth (m-d-y)

6. Does the Employee Speak English? If No, Specify Language

YES ○ NO ○

7. Race

Black ☐ Asian ☐ White ☐

8. Ethnicity

Native American ☐ Other ☐ Hispanic ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status

Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Primary Doctor's Name

14. Doctor's Mailing Address

City State Zip Code

15. Date of Injury (m-d-y)

16. Time of Injury : am ○ pm ○

17. Date Lost Time Began (m-d-y)

18. Type of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ○ NO ○

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street, P.O. Box, or School Name County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y)

30. Name and Title of Person Completing Form

31. Name of Business

Killeen Independent School District

32. Business Mailing Address and Telephone Number

Street or P.O. Box: P.O. Box 967

Telephone: (254) 336-0068

City: Killeen State: TX Zip Code: 76540

33. Business Location (If different from mailing address)

Number and Street: 2301 Atkinson Avenue

City: Killeen State: TX Zip Code: 76543

34. Federal Tax Identification Number: 74-6001505

35. Primary North American Industry Classification System Code:(6 digit) 61111

36. Specific NAICS Code (6 digit)

37. Texas Comptroller Taxpayer No.: 99-99021-0

38. Workers' Compensation Insurance Company: Texas Association of Schools Boards (TASB)

39. Policy Number: WC-1200

40. Did you request accident prevention services in past 12 months?

YES, ○ NO ○ If yes, did you receive them? YES ○ NO ○

41. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____

KILLEEN INDEPENDENT SCHOOL DISTRICT
Clinic- Employee Incident Report (Print in Ink)

Employee's Name: _____ Date of Birth: _____

Campus: _____ Occupation: _____

Date of Incident: _____ Time of Incident: _____

Description of Incident:

Complaint/Observation (Medical):

Incident reported to clinic:
Time: _____ Nurse/Aide: _____

Clinic Action:

First report of Injury Submitted to Risk Management: yes ☐ no ☐

Photo Taken: Yes ☐ No ☐ Photo Emailed: Yes ☐ No ☐

(bites, cuts, wounds etc..)

_____ _____
Nurse/Aide Signature Date

** If a nurse/clinic aide is not available to evaluate the injured employee or if it is after regular business hours, completion of this form is not required.

1 copy to each of the following: Risk Management, Health Services, File copy

Revised 3/30/2021

Employee Statement

Killeen Independent School District
Employee's Report of Accident/Injury

Name of employee:_____ Employee ID#: _____

Location of accident/injury ◉classroom ○hallway ○gym ○kitchen ○playground
○other _____

Campus/Department: _____

Employee title: _____

Date of Injury;____/___/_____ Time:_____ ○am ○pm

Witness name (s): _____

_____

Description of accident: _____

_____

_____

_____

_____

Indicate body part (s) affected ○ left ◉ right

_____

Is there any other body parts affected ◉yes ○no
If yes, what part(s)? _____

Could accident have been prevented? ○yes○no
If no, why not? _____

_____

_____

If yes, how? _____

_____

_____

Employee's Signature: _____ Date signed: _____

Witness Statement

Killeen Independent School District
Witness Report of Accident/Injury

Name of injured person: _____

Name of Witness: _____

◯ Employee ◯ Student ◯ Other _____

Location of accident/injury: _____

Campus/Department: _____

Witness job title: _____

Date of Injury; ____/___/_____ Time: _____ ◯ am ◯ pm
Did you witness the accident? ◯ yes ( ) no

Description of accident:
_____

_____

_____

_____

_____

Body part (s) injured: ◯ left _____ ◯ right _____
_____
_____

Could accident have been prevented? ◯ yes ◯ no
If no, why not? _____
_____
_____

If yes, how? _____
_____
_____

Witness Signature: _____ Date: _____

KILLEEN INDEPENDENT SCHOOL DISTRICT ELECTION TO USE PAID LEAVE/ WITH WORKERS' COMPENSATION

Name:_____ **Employee ID#:** _____

Position:_____ **Campus/Department:** _____

Date of Injury _____ **First day of absence from work due to job related injury/illness**_____

This employee is absent from duty because of a job-related 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.

Mail or fax (254-336-0091) this election form with a selection made to the Risk Management Office within 48 hours of your claim if you have lost time because of this injury/illness.

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. *Weekends are counted toward to the 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: *(Please check one)*:

☐ I choose to use only_____days of available paid leave at this time. (You must indicate number of days)

☐ 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 Killeen 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: _____

Mail or fax (254-336-0091) this election form with a selection made to the Risk Management Office within 48 hours of your claim if you have lost time because of this injury/illness.

Please contact the Risk Management Office at (254) 336-0068 for questions pertaining to this form.

KILLEEN INDEPENDENT SCHOOL DISTRICT
ELECTION TO USE PAID BENEFITS WITH WORKERS' COMPENSATION

BENEFITS ELECTION

Name:_____ **Employee ID#:** _____

District policy CRD states that, "an employee who is not on paid leave status or FMLA leave shall be allowed to continue group health insurance coverage, at his own expense, for the period specified in the District's group health insurance plan."

This page allows you to select how your benefits are paid while you are off work because of a work related injury. Please determine whether you are eligible for FMLA prior to completing this form. I am absent from duty because of a job-related illness or injury. I am aware of the requirement for FMLA to run concurrently with workers' compensation and understand that selecting one the options below will allow my benefits to continue during my absence. I choose the following option for continuance of my benefits: (*Please check one)*

☐ I am eligible for FMLA and elect for Killeen ISD to pay my portion of employee benefits (Insurance Premiums) for a period of up to six weeks. By initialing this box, I understand that I will be liable for any overpayments that are incurred during the six-week period of benefit payout. In addition, if an overpayment results, I agree to pay any overpayments due through payroll deduction upon notice or through alternative methods.

☐ I am not eligible for FMLA and elect for Killeen ISD to pay my employee benefits (**both** employee and employer portion of Insurance Premiums) for a period of up to six weeks. By initialing this box, I understand that I will be liable for any overpayments that are incurred during the six-week period of benefit payout. In addition, if an overpayment results, I agree to pay any overpayments due through payroll deduction upon notice or through alternative methods.

☐ I elect to waive payments of my portion of employee benefits through payroll. I understand that I will have to contact the benefits office to make payment arrangements for my employee portion of benefits. I realize that if I do not make arrangements my benefits may be cancelled.

_____ _____

Employee signature **Date**

KILLEEN ISD EMPLOYEE ACKNOWLEDGEMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I 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

_____

Employee ID #

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,call the Risk Management Office at (254) 336-0068 or your adjuster at 800-482-7276.

RETURN THIS FORM TO: Killeen Independent School District
Risk Management
Office P.O. Box #967
Killeen, TX 76540
(254) 336-0091 (Fax)

To be completed by employer only:

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification Date of Injury: (____/_____/_____)