



OFFICE OF HUMAN CAPITAL MANAGEMENT
Benefits & Risk Management

Midland Independent School District
615 W. Missouri Ave., Midland, TX 79701
432-240-1000 • midlandisd.net

Workers' Compensation Packet

Please see the steps below to follow in the event an employee is injured on your campus and is planning to seek medical treatment. **All steps must be followed prior to the employee seeking medical treatment** unless the injury is a medical emergency and the employee is unable to complete the forms before treatment.

Step 1: First Report of Injury (FROI)

Have the injured employee complete the paper FROI and give it to their campus secretary. The campus secretary must enter the information on the [TASB website](#) no later than 24 hours from the injury. **The original FROI must be sent to The Benefits Department as soon as possible. Click [here](#) for secretary instructions on how to file the FROI online.**

Step 2: Employee Acknowledgement of the Alliance Program

Please have the injured employee sign and date this form. Make a copy for the employee and send the original signed form to The Benefits Department.

Step 3: Advise Employee of Treating Physician for Workers' Compensation

Nova Medical Center
2501 W. Illinois Ave
Midland, TX 79703
(432) 203-0200

****If the employee does not go to our designated Workers' Compensation physician they run the risk of their medical and/or income benefits being disputed.**

Step 4: Provide Employee with Temporary Rx Prescription Card

The employee will use this prescription card if any medication is prescribed to them due to their workers' compensation injury. **Please advise the employee not to use their Blue Cross Blue Shield Rx Card for their workers' compensation injury.**

Step 5: Have the Employee Complete the Leave Election Form

The employee must sign the leave election form to advise if they are wanting to use their available leave when out of work due to a work-related injury. This is required in order to determine how to code their absences in Frontline. **If the employee is losing time please notify the Benefits Department as soon as possible (432) 240-1824.**

Texas Association of School Boards Risk Management Fund (TASBRMF) administers MISD Workers' Compensation Claims. The injured employee should expect a call from a TASBRMF Workers' Compensation Adjuster once their claim has been set up. 1-800-580-8272.



OFFICE OF HUMAN CAPITAL MANAGEMENT
Benefits & Risk Management

Midland Independent School District
615 W. Missouri Ave., Midland, TX 79701
432-240-1000 • midlandisd.net

**DETAILED CAMPUS
INSTRUCTIONS
ON THE FOLLOWING
PAGES**

How to File a First Report of Injury

Campus or Department Instructions

Start here: tasbrmf.org/claims

TASB RISK FUND

About Us | Contact Us | Report a Claim | Login

Programs | Member Service Center | Learning & News

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

Report a Claim

Report a Claim

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

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

Workers' Compensation claims

First Report of Injury

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

First Report of Injury WC Claim

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

Organization

Report a WC Claim

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

First Report of Injury guides

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

myTASB Access

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

Your Marketing Consultant

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

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

TASB RISK FUND

Reporting a Claim Log Out and Exit

What you will need:

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

What you should know:

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

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

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

Chat now

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

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



New First Report of Injury Complete Incident or Cancel

Employer General Information

Member	Education ISD	Mailing Address	PO Box 123
Physical Address	123 1 st Street	City	Your City
City	Your City	State	Texas
State	Texas	ZIP	00000
ZIP	00000		
FEIN	12345678		
Phone	(123) 456 7890		
Is this a corrected copy? *	<input type="text" value="No"/>		

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

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

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

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

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

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

Address where Injury/Illness Occurred

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

Employee Information

First Name *
Middle Name
Last Name *
Street Address 1 *
Street Address 2
City *
State *
ZIP *
Phone *
Work Phone
Employee Email
Does the employee speak English?

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

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

Birth Date *
Social Security ⓘ *
Other Employee ID
Other Employee ID Qualifier
Hire Date *
Length of Service Years
Length of Service Months
Hire State *
Gender *
Marital Status *
Occupation/Job Title *
Payroll Class Code *
Occupation Code *
Department Code, if applicable
Employment Status *
Number of Dependents

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

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

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

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

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

Wages

Wage Rate *

Wage Rate Type ⓘ *

Days Worked Per Week *

Hours Worked Per Week

Full Pay On Day Of Injury

Did Salary Continue?

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

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

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

Gross Amount of Last Paycheck

Type of Pay ⓘ

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

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

Leave these boxes blank for now.

Occurrence Information

Date of Injury/Illness *

Time Employee Began Work

Time of Injury or Illness Exposure *

Date Employer Notified *

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

Was the injury or illness exposure fatal?

Employee's Supervisor

Supervisor Phone Number

Type of Injury/Illness *

Part of Body Affected *

Cause of Injury *

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

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

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



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

Worksite location of injury ⓘ

Examples include walking, cleaning, or cooking.

Was employee doing their regular job?

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

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

How did the injury or illness exposure occur? ⓘ *

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

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

Type of Claim ⓘ *

Record Only is for no medical treatment, no lost time, and no questions or concerns.
Medical Only is for initial medical and/or no more than 5 days of lost time.
Lost Time/Indemnity is for ongoing medical treatment and/or lost time and all other.

Treatment Information

Medical Provider

Physician/Hospital Name

Address

City

State

ZIP

Phone

Fax

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

Initial Treatment *

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

Other Information

Date Administrator Notified

Date Prepared *

Preparer's Name *

Preparer's Title *

Preparer's Phone *

E-mail address to receive confirmation

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

Leave this blank for your FROI Administrator to complete.

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

Witness

Witness Phone #

All Other Information

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

New First Report of Injury Complete Incident or Cancel

Address

City

State

ZIP

Phone

Fax

Initial Treatment *

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

Other Information

Date Administrator Notified

Date Prepared *

Preparer's Name *

Preparer's Title *

Preparer's Phone *

E-mail address to receive confirmation

Witness

Witness Phone #

All Other Information

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

Chat now

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

How to Refresh your browser:

- Chrome: Hold down Ctrl and press F5
- Chrome & Mac: Hold down Command, Shift and click the 'R' key
- Firefox & Windows: Hold down Ctrl and press F5
- Firefox & Mac: Hold down Command, Shift and the 'R' key
- Safari: Hold down the option and command key then press the 'E' key
- Internet Explorer: Hold the Control key, press the F5 key.

Filename	Description	Folder	Entry Date
EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS CLAIM.pdf	FROI DWC-01	Claims	12/07/2020 12:06 PM

If you have questions contact your FROI Administrator or inquiry@tasb.org or 800.482.7276