CAMPUS - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

For Emergencies please direct employee to nearest Emergency Room. If possible ensure Employee has completed the First Report of Injury (FROI).

☐ Go to this link at www.tasbrmf.org and complete **First Report of Injury and file no later than the next business day**. You do not need to log in to complete the First Report of Injury.

☐ Have Employee sign **Acknowledgement of Medical Alliance** – Return original to the Benefits Department

☐ If Employee feels he/she may seek medical treatment complete and give the employee the **Optum First Fill® Program Form.**

☐ If Employee feels he/she may seek medical treatment advise them our WC Doctor is Nova Medical. Inform employee to submit any Work Status Reports directly to the Benefits Department immediately after leaving Nova.

☐ Have Employee advise whether they wish to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form.

Send all signed forms and paperwork by the next business day to:
Benefits Department
Phone: (432) 240-1952

Please refer injured employee directly to the Benefits Department for any further questions or issues regarding any workers' compensation injury. Alert Benefits immediately if employee misses any time, returns to work, or if there are any questions or concerns.

MISD Workers' Compensation Doctor:
Nova Medical Center
2501 W. Illinois
Midland, TX 79703

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

Verification of Employment for a Reported Workers' Compensation Injury or Illness

(Please take this form to the doctor for your first medical examination.)

Employee Name _____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

_____

_____

_____

Midland ISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an your School District's WC Doctor: Nova Medical Center 2501 W. Illinois Midland, TX 79703

Please submit all claim and medical billing information to:

TASB Risk Management Fund
PO Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276
Fax: (800) 580-6720
Pre-Authorization
Phone: (800) 482-7276 ext. 9907
Fax: (888) 777-8272

Issuing Signature _____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description enquiries to:
The Benefits Department
Email: benefits@midlandisd.net
Phone: (432) 240-1950
Fax: (432) 689-5869

FORM TO ELECT LEAVE BENEFIT S WITH WORKERS' COMPENSATION (NO OFFSET—ENGLISH VERSION)

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 Midland 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 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

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: _____

FORM TO ELECT LEAVE BENEFIT S WITH WORKERS' COMPENSATION (NO OFFSET—SPANISH VERSION)

Nombre _____ **Numero de empleado** _____

Posicion _____ **Departamento/Campus** _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en *(fecha de la primera ausencia que se atribuye a enfermedad o lesión)*. Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

_____ _____

Firma autorizada de distrito Fecha

Eleccion del empleado:

Estoy ausenté del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia con goce de sueldo y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia sin goce de sueldo que no sea una licencia FMLA. Elijo la siguiente opción:

☐ Elijo utilizer solamente _____ dias de licencia disponible con goce de sueldo en esta oportunidad.

☐ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré losbeneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabadotoda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalentea mi sueldo previo a la enfermedad o a la lesión.

☐ Elijo no utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que norecibiré pagos de salario regulares de Midland ISD mientras reciba los beneficios de ingresosemanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce desueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción,recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausenciasque deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comuniqueal distrito un cambio en mi decisión.

_____ _____

Firma del empleado Fecha

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

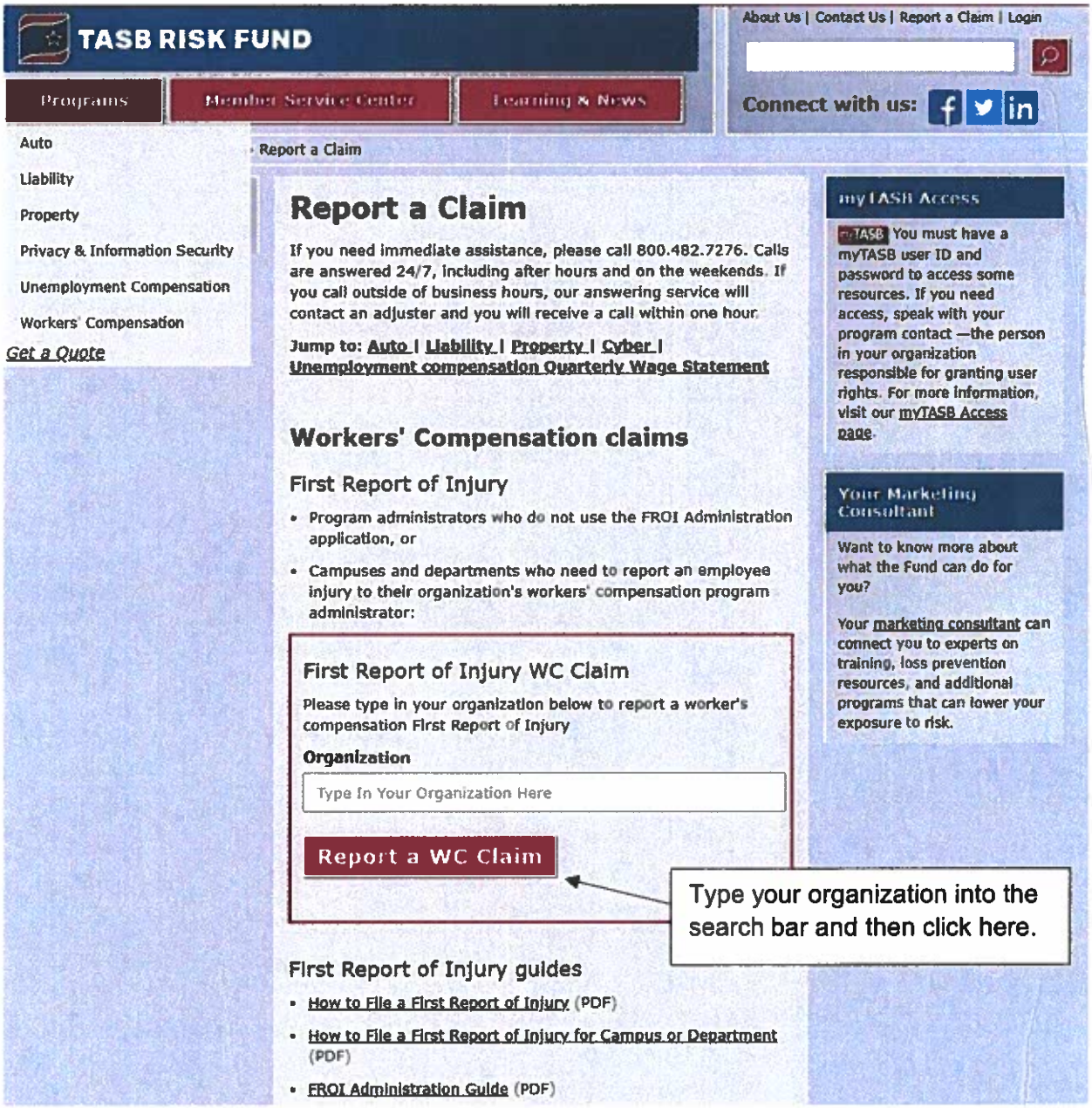
For hourly employees only:
Hourly rate: $____.___
Number of hours paid: _____

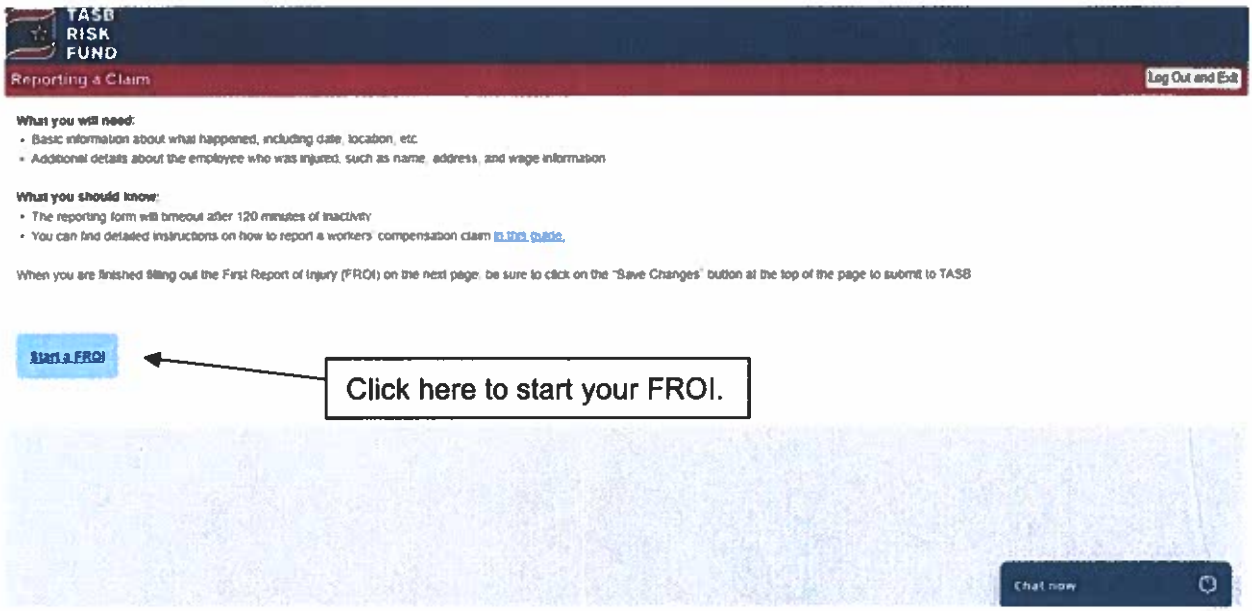
TASB RISK MANAGEMENT FUND

How to File a First Report of Injury

Campus or Department Instructions

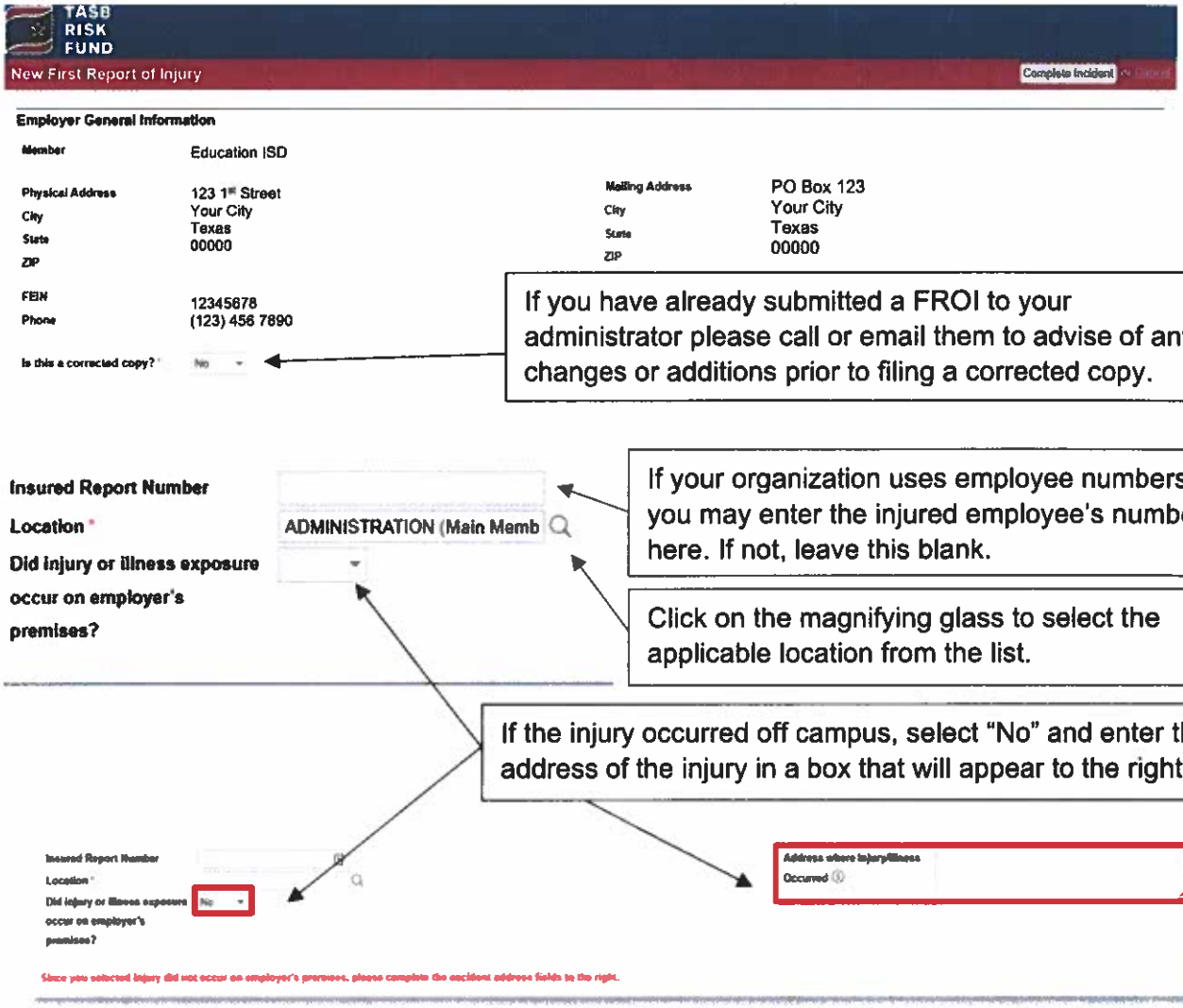
Start here: **tasbrmf.org/claims**



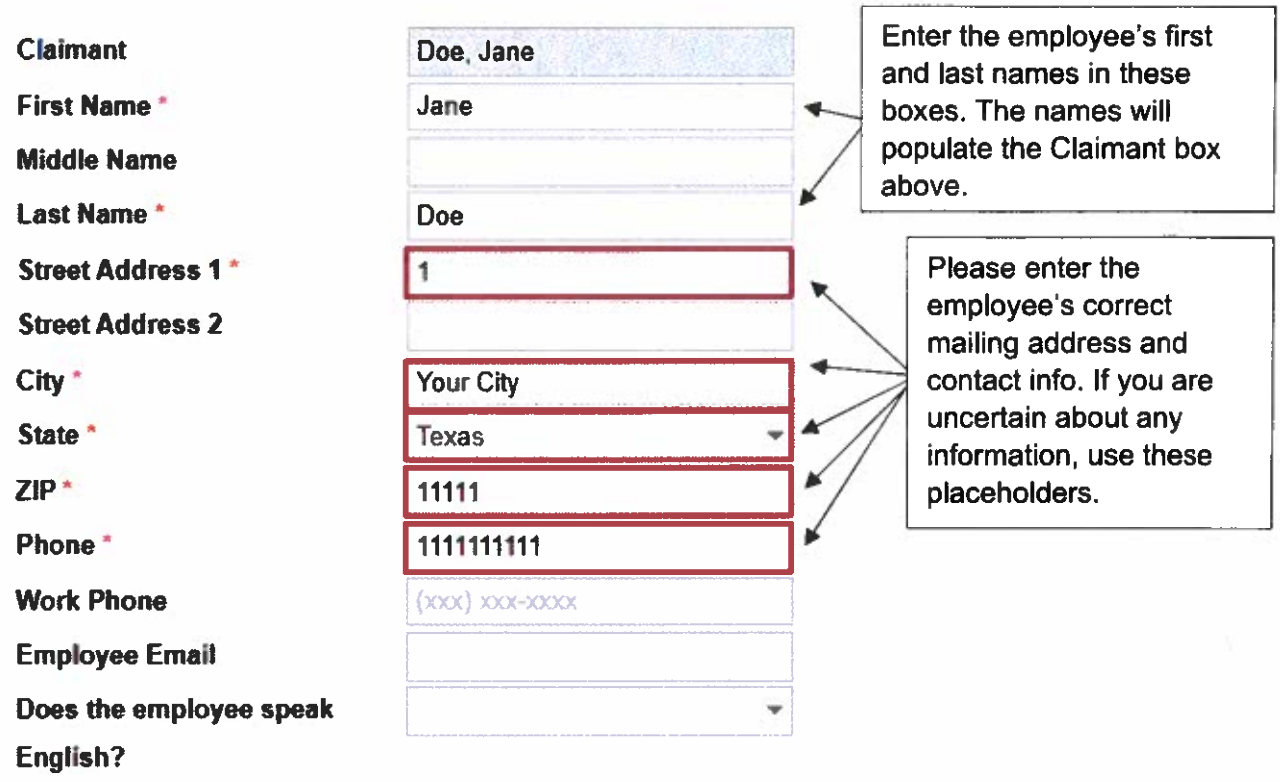


Important: Please note that all items marked with a red asterisk (*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

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



Employee Information



Birth Date *	01/01/2010
Social Security *	111-11-1111
Other Employee ID	
Other Employee ID Qualifier	
Hire Date *	01/01/2010
Length of Service Years	0
Length of Service Months	
Hire State *	Texas
Gender *	Not Specified
Marital Status *	Unknown
Occupation/Job Title *	Teacher
Payroll Class Code *	PROFESSIONAL/ADMINISTR
Occupation Code *	PROFESSIONAL/CLERICAL/
Department Code, if applicable	
Employment Status *	Regular/Full-time Employee
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.

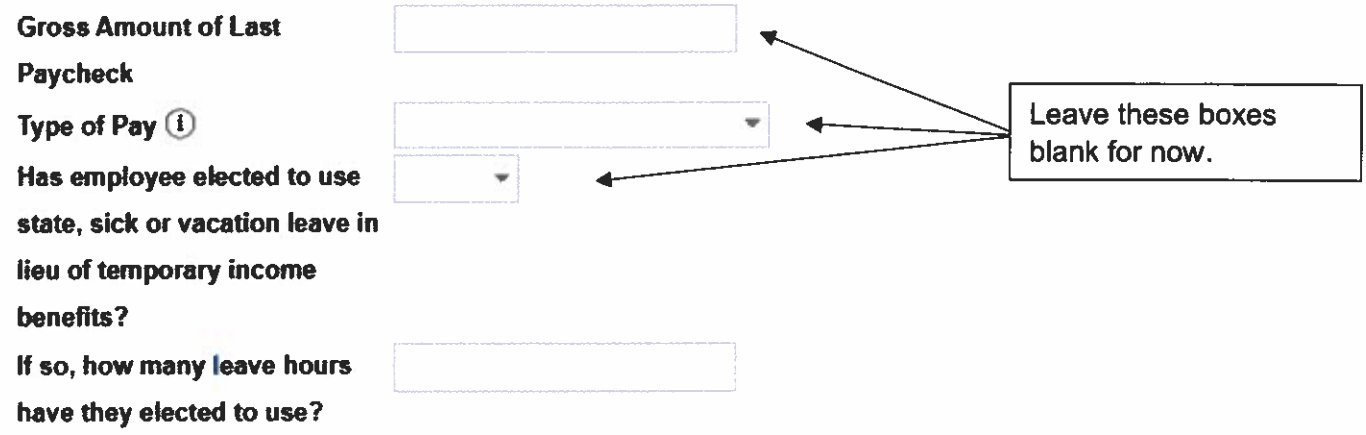
Wages

Wage Rate *	1.00
Wage Rate Type *	Daily
# Days Worked Per Week *	5
# Hours Worked Per Week	
Full Pay On Day Of Injury	Yes
Did Salary Continue?	

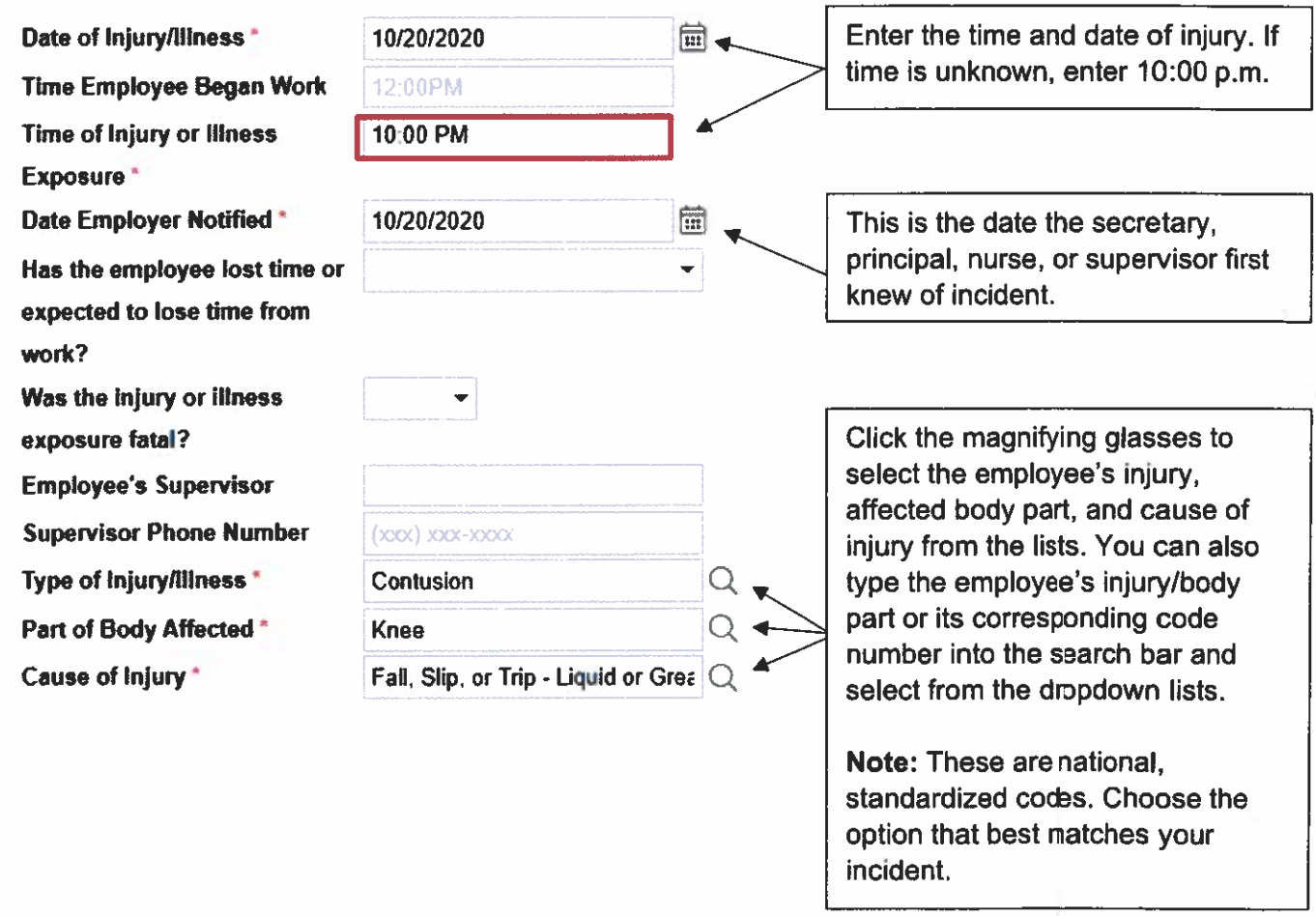
Please enter 1.00. Your administrator will input exact wage rate later.

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.



Occurrence Information



Worksite location of injury ⓘ

Was employee doing their regular job?

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

Walking through hallway

How did the injury or illness exposure occur? ⓘ *

Slipped in puddle and fell on left hip

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

Examples include walking, cleaning, or cooking.

Briefly explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** If you need more space to complete injury description, use the "All Other Information" box at the end of this form.

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

Yes

Type of Claim ⓘ *

Medical Only

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 (xxx) xxx-xxxx

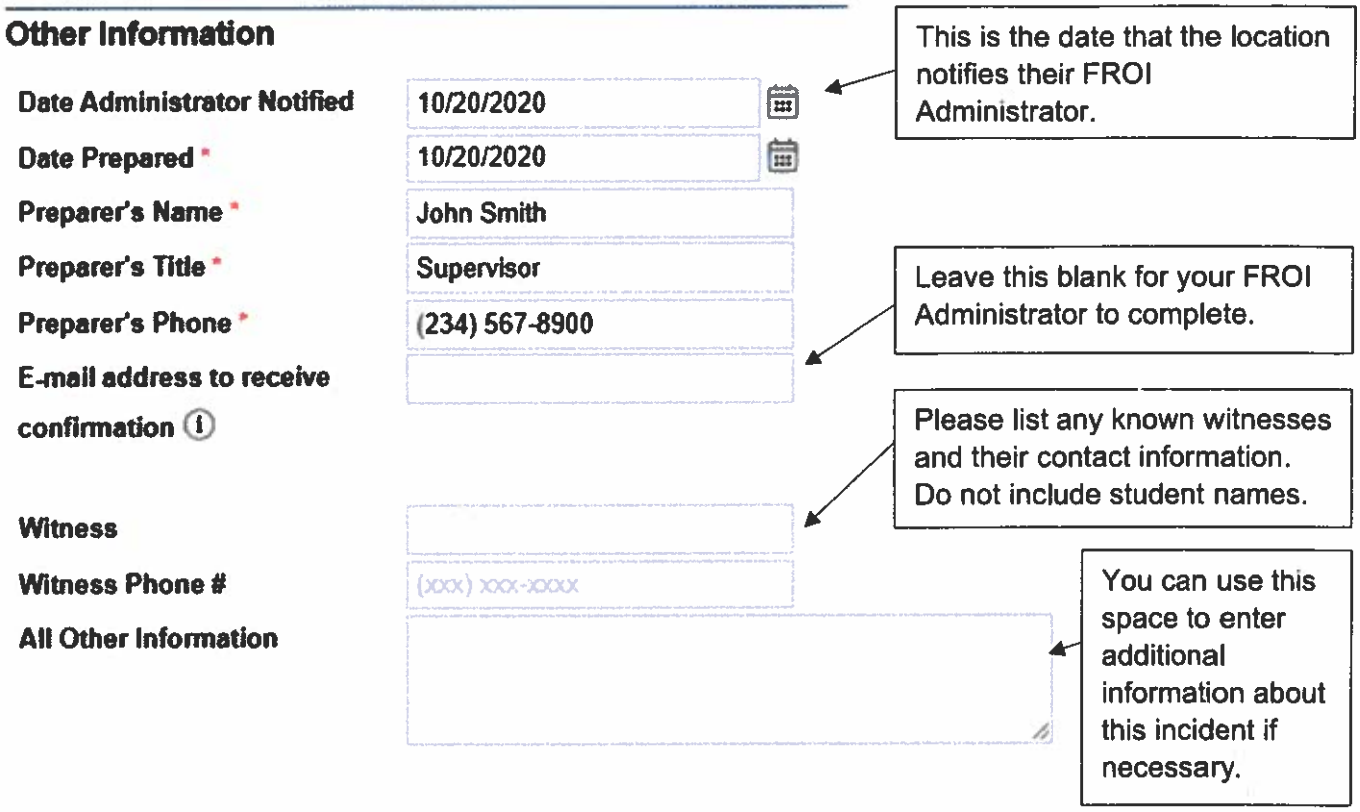
Fax (xxx) xxx-xxxx

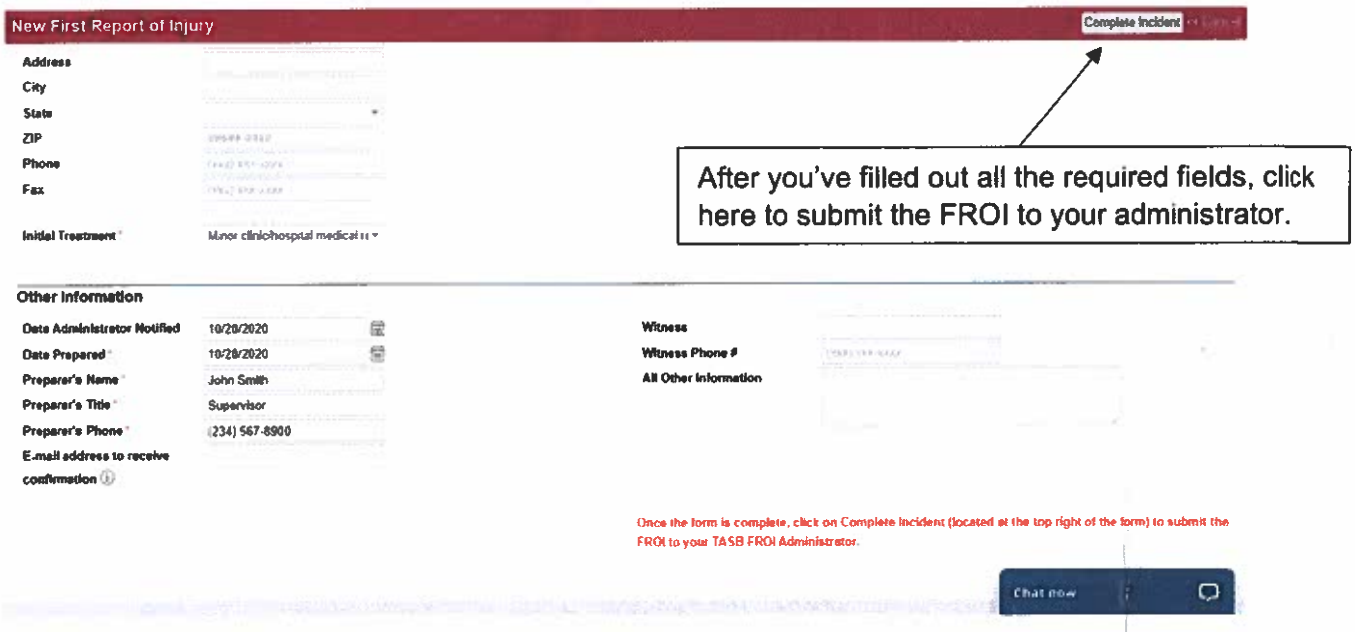
Enter doctor/hospital information if known. These are not mandatory fields. Don't worry about inputting addresses.

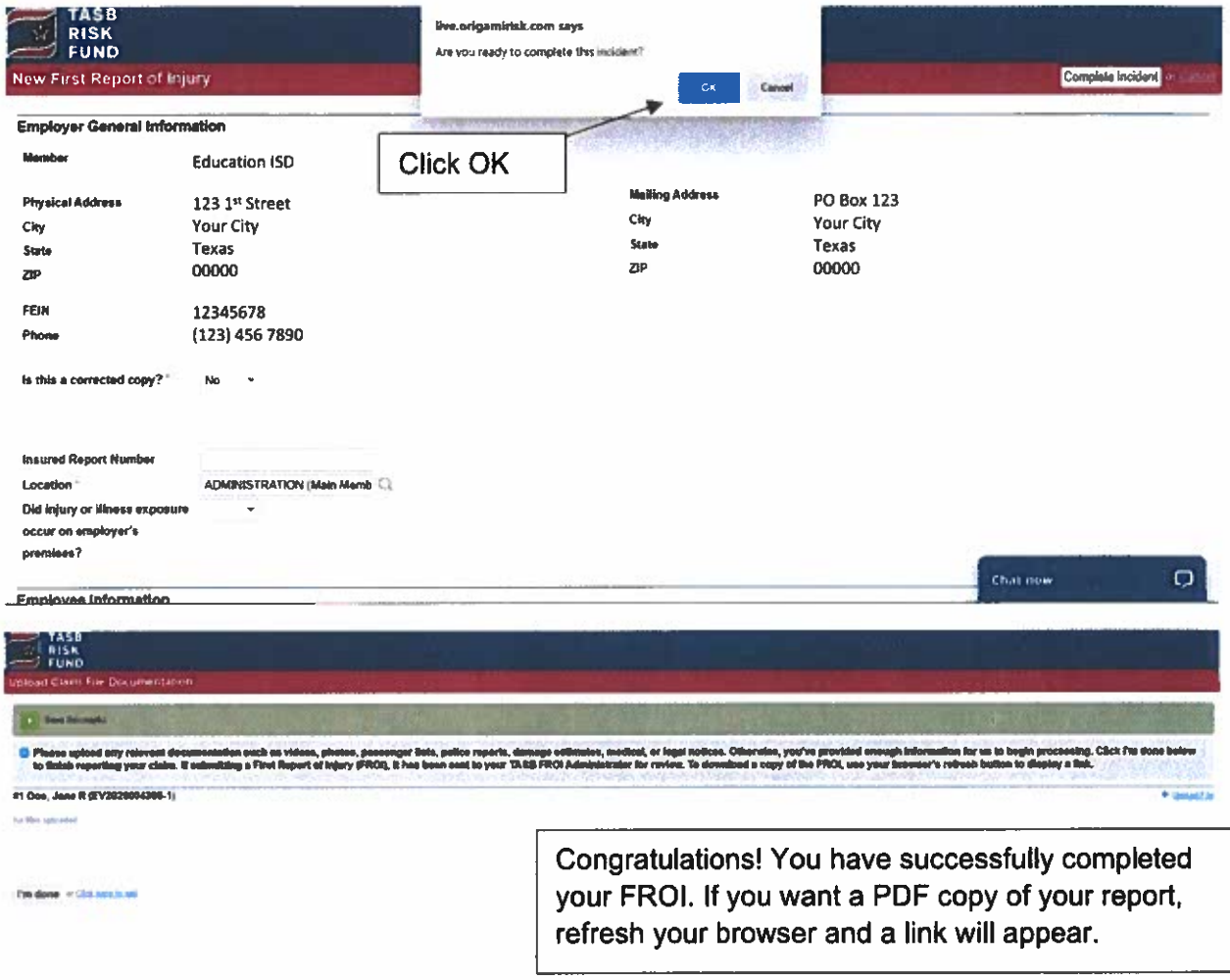
Initial Treatment *

Minor clinic/hospital medical re

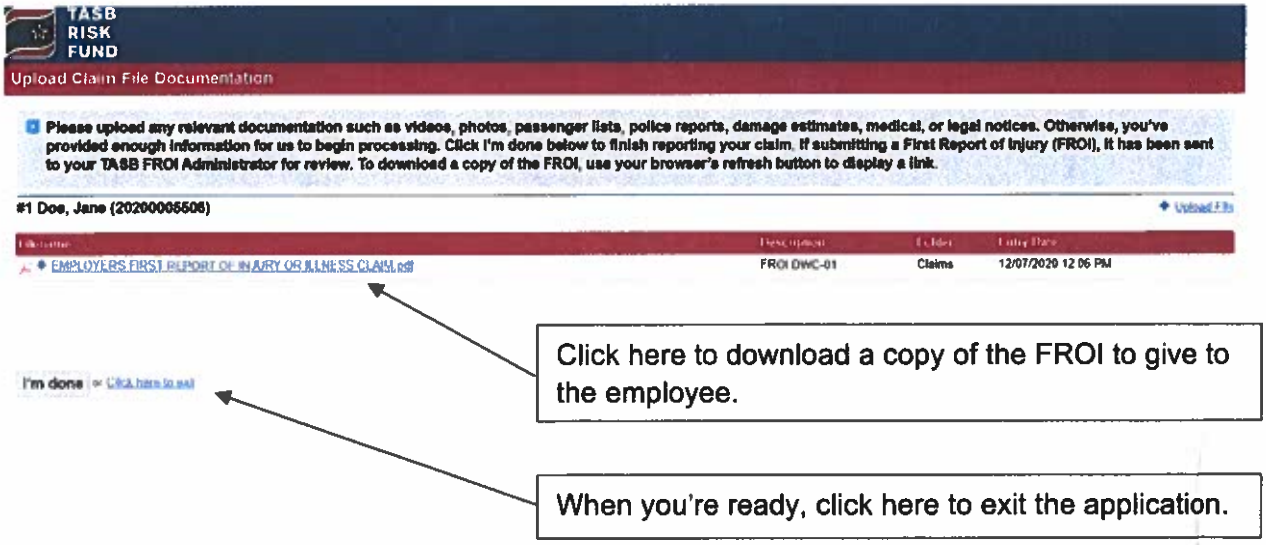
This field is mandatory. Select the appropriate option from the dropdown list.







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



Click here to download a copy of the FROI to give to the employee.

When you're ready, click here to exit the application.