

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.



**TASB RISK
MANAGEMENT FUND**

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 BENEFITS 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: _____

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FORM TO ELECT LEAVE BENEFITS 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

Elección del empleado:

Estoy ausente 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 utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.
- Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabado toda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalente a 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 no recibiré pagos de salario regulares de Midland ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo 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 ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al 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: _____

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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

Connect with us: [f](#) [t](#) [in](#)

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 [here](#).

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.

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		
FBN	12345678		
Phone	(123) 456 7890		
Is this a corrected copy?	<input type="radio"/> 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?

ADMINISTRATION (Main Memb

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?

No

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









Claimant	Doe, Jane
First Name *	Jane
Middle Name	
Last Name *	Doe
Street Address 1 *	1
Street Address 2	
City *	Your City
State *	Texas
ZIP *	11111
Phone *	1111111111
Work Phone	(xxx) xxx-xxxx
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.



Campus or Department Instructions for Filing a First Report of Injury - 5 -

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.



Campus or Department Instructions for Filing a First Report of Injury - 7 -

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 *

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.

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? *

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.

Type of Claim ⓘ *

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	<input type="text" value="10/20/2020"/>	
Date Prepared *	<input type="text" value="10/20/2020"/>	
Preparer's Name *	<input type="text" value="John Smith"/>	
Preparer's Title *	<input type="text" value="Supervisor"/>	
Preparer's Phone *	<input type="text" value="(234) 567-8900"/>	
E-mail address to receive confirmation ⓘ	<input type="text"/>	
Witness	<input type="text"/>	
Witness Phone #	<input type="text" value="(xxx) xxx-xxxx"/>	
All Other Information	<input type="text"/>	

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.

You can use this space to enter additional information about this incident if necessary.

New First Report of Injury Complete Incident

Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
ZIP	<input type="text" value="09544 0102"/>
Phone	<input type="text" value="(442) 851-1024"/>
Fax	<input type="text" value="(442) 851-1024"/>
Initial Treatment *	Minor clinic/hospital medical

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

Other Information

Date Administrator Notified	<input type="text" value="10/20/2020"/>	
Date Prepared *	<input type="text" value="10/20/2020"/>	
Preparer's Name *	<input type="text" value="John Smith"/>	
Preparer's Title *	<input type="text" value="Supervisor"/>	
Preparer's Phone *	<input type="text" value="(234) 567-8900"/>	
E-mail address to receive confirmation ⓘ	<input type="text"/>	

Witness	<input type="text"/>
Witness Phone #	<input type="text" value="(xxx) xxx-xxxx"/>
All Other Information	<input type="text"/>

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



Campus or Department Instructions for Filing a First Report of Injury - 9 -

live.origamirisk.com says
Are you ready to complete this incident?

OK **Cancel** **Complete Incident**

Employer General Information

Member: Education ISD

Physical Address: 123 1st Street
City: Your City
State: Texas
ZIP: 00000

Mailing Address: PO Box 123
City: Your City
State: Texas
ZIP: 00000

FEIN: 12345678
Phone: (123) 456 7890

Is this a corrected copy? No

Insured Report Number: [Field]
Location: ADMINISTRATION (Main Memb)
Did injury or illness exposure occur on employer's premises? [Field]

Employee Information

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.

Upload Claim File Documentation

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, Jane (20200005508)

File Name	File Upload	Folder	Entry Date
EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS CLAIM.pdf	FROI DW-01	Claims	12/07/2020 12:06 PM

I'm done

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

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

