Sharyland Independent School District

Insurance Department Workers' Compensation Program

❖ Email the completed form to Insurance Specialist or fax to 956-580-5224.

Employee's Claim for Compensation for a Work-Related Injury (DWC1)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one or two days** of the date of injury.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐Male ☐Female
Race / Ethnicity ☐White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐Separated ☐Single ☐Divorced		
Campus / Department Location:	**Work Scheduled** ______: _____AM / _____: _____PM	
Occupation at time of injury	**Work Phone Extension:**	**Work status** ☐Full-Time ☐Part-Time
Complete Address of Campus or Department Location:		
Was Employee Doing Regular Job? ☐ Yes ☐ No		**Date of hire** (mm / dd / yyyy)

II. INJURY INFORMATION

Nature of Injury (Skip, Fall, Contusion, Etc.)	**Date of Injury** (mm / dd / yyyy)	**Time of Injury**
Location of Injury (Classroom, Gym, Hallway, Etc.)	**Cause of Injury (Tool, Backpack, Chair, Etc.)**	
Witness(es) to the Injury (list by name)		
Describe cause of injury, including how it is work related		
Body part(s) affected or exposed by the injury		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION **Do you wish to see a Doctor?** ☐ Yes ☐ No

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Could this accident have been prevented? ☐ Yes ☐ No	**Yes, how**

Print Name of person filling out this form on behalf of injured employee **Date**

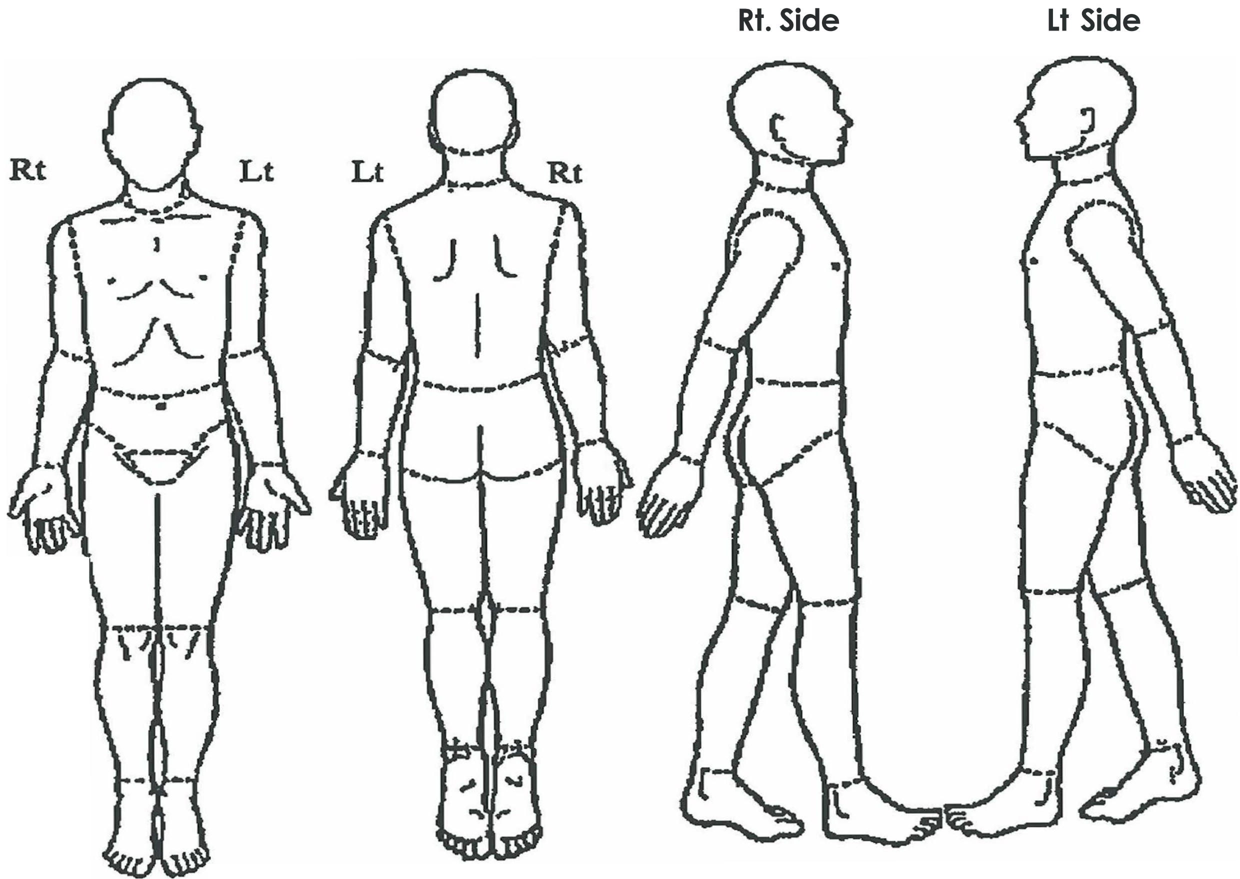
Signature of injured employee **Date**

- **REMIND EMPLOYEE:** AFTER FIRST DOCTOR VIST, EMPLOYEE MUST REPORT TO WORKERS' COMPENSATION OFFICE BEFORE RETURNING TO WORK.
- EMPLOYEE MUST RECEIVE THE EMPLOYEE RIGHTS AND RESPONSIBILITY INFORMATION.
- IF EMPLOYEE SEEKS MEDICAL TREATMENT BY DOCTOR THE WORKERS' COMPENSATION VERIFICATION OF COVERAGE MUST BE GIVEN TO EMPLOYEE TO TAKE TO DOCTOR'S OFFICE AND PHARMACY.

Sharyland Risk Management Program
Body Diagram

Name: ________________________________ **SS#:** XXX-XX-___________ **DOI:** __________

On the diagram provided below, please circle the parts of your body where you are experiencing pain due to this injury.



- **I hereby certify that the information above this form is true and correct to the best of my knowledge.**
- **I understand that any falsification of information regarding an on-the-job or illness may result in disciplinary action and or prosecution under the appropriate State Criminal Statutes.**

___________________________ ___________________________

Employee's signature **Date**

Sharyland I.S.D.
Insurance Department / Workers' Compensation Program
1200 N. Shary Rd., Mission, TX 78572
956-580-5200 x 1108

WORKERS' COMPENSATION VERIFICATION OF COVERAGE

Take this Form to Doctor's, Hospital Visit or Pharmacy with Prescription

(Name)__________________________ has reported a work-related injury/ illness that occurred on (DOI)__________________. This may be covered under Workers' Compensation benefits. Contact Tristar Risk Management at the address below to authorize reasonable and necessary medical treatment, and to file expenses incurred for this claim.

Mail Claims to:
Tristar Risk Management
PO BOX 2805
Clinton, Iowa 52733-2805

Toll Free: 800- 593-0020 or Phone: (361) 857-0115
Fax: (361) 857-0123

Amy Kwast - Claim Supervisor
Amy.Kwast@tristargroup.net
ext. 2923

Terry Cherry - Claim Examiner III
Terry.Cherry@tristargroup.net
ext. 3014

Aracelia "Sally" Hernandez - Claims Examiner I
Aracelia.Hernandez@tristargroup.net
ext. 3015

Lizette Silguero - Claims Assistant
Lizette.Silguero@tristargroup.net
ext. 3011

Attention Doctor's Office

FAX

DWC73 to 956-580-5224
as soon as possible

Rev. 04/13

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

The disclosure of records authorized herein is required for the administration of a claim.

Medical provider: ____

Patient name:____
Medical record number: ____
Date of birth: ________________
Address:_____________________
Telephone number: ____________
Claim number: ________________
Email:_______________________________________

Recipient name: TRISTAR through its Copy Service Agent
Recipient address: P.O. Box 2805, Clinton, IA 52733-2805
Recipient telephone number: (800)593-0020

Health information requested:
X_All medical records.

Purpose: Processing / administration of ______________'s workers' compensation claim.

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (check all that apply):

___Mental health records.
___Alcohol or drug records.
___HIV test results.

Method of delivery of requested records:
___Mail
___Pick up
___Electronic delivery, recipient email:____

This authorization is effective until the workers' compensation claim is fully resolved or unless a different date is specified here ________________(Date).

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient signature*:____
Date: ________________
Print name: ____

*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

___Parent or guardian of minor patient who could not have consented to health care.
___Guardian or conservator of an incompetent patient.
___Beneficiary or personal representative of deceased patient.

Specialty	Facility	Name	Prof.Designation	Address 1	Address 2	City	State	ZIP	Phone
Fam. Practice/Urgent Care	Valley Day & Night Clinic		FP/UCC	305 E Expressway 83		Mission	TX	78572	956-585-7401
Family Practice	Industrial Health Works Family Day & Night Clinic	Bose, Ashley	MD	801 E Nolana	Suite 9	McAllen	TX	78504	956-668-7333
Family Practice	Family Physicians Clinic & Valley Night Clinic		Clinic	606 S Broadway		McAllen	TX	78501	956-682-4515
Family Practice	McAllen Primary Care Clinic/McAllen Family Urgent Care	Sergio Diaz, PA	MD	110 East Savannah	A204	McAllen	TX	78503	956-686-4040
General Practice	Rio Occupational Institute, LLC	Dr. Mario Vasquez Aguilar	MD	2501 Buddy Owens Blvd.		McAllen	TX	78504	956-631-6109
Ortho Surgery	Rio Grande Valley Orthopedic Center	Dr. Guillermo Pechero	Orthopedic Surgeon	1005 E. Nolana Ave.		McAllen	TX	78504	956-686-6510
Ortho	McAllen Orthopedics Associates	Dr. Gregory Goldsmith	MD / Orthopedics	110 E Savannah	Bldg. B-101	McAllen	TX	78503	956-686-1575
Physical / Occupational Therapy	Evolutions Therapy	Natasha Odendaal	OTR, OTD, CHT, CLT, C/NDT	5225 S. Mccoll Road		Edinburg	TX	78539	956-627-2142
Physical / Occupational Therapy	Evolutions Therapy	Janet Tan	PT, DPT	5225 S. Mccoll Road		Edinburg	TX	78539	956-627-2142
Physical Therapy	Puig Physical Therapy	Robert Puig	Physical Therapy	2122 E Griffin Pkwy		Mission	TX	78572	956-585-8886
Physical Therapy	Puig Rehabilitation	Kevin Abers	Physical Therapy	500 E Dove		McAllen	TX	78504	956-686-3434
Physical Therapy	Terry Physical Therapy		Physical Therapy	1918 E Griffin Pkwy		Mission	TX	78572	956-583-2995
Radiology	Optimum Imaging Center		Imaging Center	500 S Bicentennial		McAllen	TX	78501	956-585-8700
Therapy & Rehab	Picasso Therapy & Rehab	Jose C. Picasso, DC	Therapy & Rehab	1001 E Griffin Pkwy		Mission	TX	78572	956-585-2225
Chiropractor	Dr. Pablo Tagle III Chiropractic Wellness Center	Dr. Pablo Tagle III	Chiropractic	3130 N. 23rd St.		McAllen	TX	78501	956-686-8060

These Are The Only Doctors and/or Facilities That Are Approved For Workers' Compensation

updated 09/2023

REPORTING PROCEDURES
For Incidents or Injuries

Sharyland ISD employees are covered by provisions of the Texas Workers' Compensation Law through a self –insurance policy.

1. If an injury or incident occurs to an employee while he/she is on duty and the incident or injury is an **"emergency"** call an ambulance or take the employee to the nearest **Hospital**.

2. It is the responsibility of the immediate supervisor, head custodian, or cafeteria manager **to immediately report any incident/injury to the campus administrator or director.**

3. The campus nurse or department secretary is responsible to obtain all the necessary information regarding the **"emergency"** incident/injury from both the employee and district personnel. The campus nurse/secretary will submit a **"First Injury/Incident Report", "Body Diagram Form" and "Authorization for Health Information Disclosure"** to the Risk Management Office via fax **(956-580-5224)** or email (auribe@sharylandisd.org).

4. If the incident is not an emergency, the campus nurse and/or secretary, will obtain the necessary first aid and evaluate the need for further medical attention. The employee must verbally report the incident to his/her supervisor as soon as possible but no later than **24 hours** after the date of the incident/injury. Maintenance and transportation employees will report incidents to the Maintenance Secretary, **Maricela Espinosa x 1076** or Transportation department secretary, **Melissa Ybarra x 2810**. ***Failure to comply will result in disciplinary action.***

5. Employees requiring additional medical treatment must notify the **Risk Management Office** prior to treatment to qualify for Workers' Compensation medical benefits. ***Employees must complete all necessary documentation for a referral to a workers' compensation approved doctor from the Workers' Compensation Network Doctors List***.

6. **After the first doctor, visit employees must report to Risk Management Office before returning to work.**

7. It is the responsibility of the employee to report or contact the **Risk Management Office** after each doctor's appointment. An employee placed on leave for an extended period of time you must make personal contact with the **Risk Management Office** on a weekly basis through the duration of the medical leave. Should an injured employee be absent for more than five (5) consecutive days, the employee must contact the Human Resources Department**.**

8. Employees must acquire a "Return to Work Status" (**RTW**) from the **Risk Management Office prior to returning to work.**

9. If any questions or concerns do not hesitate to call the **Risk Management Office at 580-5200**.

Mark Dougherty, Risk Manager – Ext. 1012
Angela Uribe, Workers Compensation / Insurance Specialist – Ext. 1108
Maricela Espinosa, Maintenance Secretary – Ext. 1076

OFFICE OF INJURED EMPLOYEE COUNSEL

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 (OIEC). 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 and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose 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. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. 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.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation 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 DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. 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. If there is something you do not understand, ask your employer or call OIEC. 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.texas.gov/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 providers 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 Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   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 DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**