Workers' Compensation Employee Reporting Procedures

Pearland ISD is committed to the safety, health, and well-being of all our employees. To ensure proper care and treatment is provided, employees sustaining a worksite injury or illness must promptly notify their immediate supervisor, administrative assistant, campus clinic, or Human Resource Services, when the injury occurs.

In the event of a medical emergency, call "911" immediately. *If the injury occurs after HRS office hours, the employee or employer representative may call TASB Risk Management Fund at* ***1-800-482-7276*** *to report the injury and obtain a claim number.*

IF NOT SEEKING MEDICAL TREATMENT – REPORTING INJURY ONLY:

1. Submit required forms within 24 hours to benefits@pearlandisd.org or fax to 281-412-1540
    a. "Employers First Report of Injury or Illness" form
    b. "Employee Acknowledgement of Alliance Direct Contracting Program" form
2. Review the Injured Worker Rights and Responsibilities made available on the district website

IS SEEKING MEDICAL TREATMENT:

1. Submit required forms within 24 hours to benefits@pearlandisd.org or fax to 281-412-1540
    a. "Employers First Report of Injury or Illness" form
    b. "Employee Acknowledgement of Alliance Direct Contracting Program" form
    c. "Use of Leave Authorization" form
    d. "Workers' Compensation Wage Benefits" form
2. Review the Injured Worker Rights and Responsibilities made available on the district website
3. Access the TASB approved network healthcare providers: https://www.pswca.org/find-a-provider.html
4. Submit medical documentation to HRS following each appointment with healthcare provider
5. Prior to reporting to work, you will need to receive a Pearland ISD HRS "Return to Work Notice"

Human Resource Services Contact Information:

Benefits Specialist, Carrie Banuelos, 832-736-6120 or ext. 66906, BanuelosC@pearlandisd.org

Senior Benefits Clerk, Claribel Perez, 281-485-3202, PerezC@pearlandisd.org

1928 N. Main
Pearland, Tx 77581

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filling.

CLAIM # ______________________

CARRIER'S CLAIM # ______________________

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☐
3. Social Security Number - -	4. Home Phone ( )
5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐	
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
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. Doctor's Name	
14. Doctor's Mailing Address (Street or P.O.Box)	
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. Nature 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 or P.O. Box / 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?	28. Supervisor's Name	29. Date Reported (m-d-y)
- -	YES ☐ NO ☐		- -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months_____Years _____	33. Length of Service in Occupation Months_____Years _____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____Days	38. Last Paycheck was: $_____for_____Hours or_____Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form Carrie Banuelos, Benefits Specialist	41. Name of Business Pearland ISD
42. Business Mailing Address and Telephone Number Street or P.O. Box: 1928 North Main Street Telephone: (832) 736-6120	43. Business Location (If different from mailing address) Number and Street
City: Pearland State: TX Zip Code: 77581	City / State / Zip Code

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
1-74-6691854-6	82114		

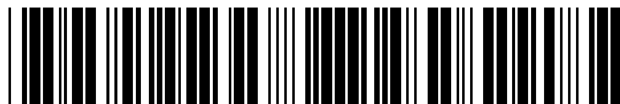
48. Workers' Compensation Insurance Company	49. Policy Number
TASB Risk Management Fund	

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

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

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

X________________________________ Date ______________



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 licensed 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 understand that 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 do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

______________________________________ ______/_____/_________
Signature Date

____
Printed Name

I live at: ____
Street Address City, State, Zip Code

Name of Employer: ____
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 **pswca.org** or call your adjuster at 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:

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

Do not return this form to the TASB Risk Management Fund unless requested.

TASB Risk Management Fund
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