District Name: Stafford MSD

# WORKERS COMPENSATION INCIDENT CHECKLIST

PRINT all information on this form.
This checklist is to be completed by the IMMEDIATE SUPERVISOR of the injured employee.
**This packet is VERY TIME-SENSITIVE.**
All forms in the packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
Once this form and all other forms in the package have been completed, please forward the entire package to the person in your district responsible for reporting the incident to ***SchoolComp***.

## SECTION I: Incident Information (Please Print Legibly)

| |
|---|
| Name of Injured Employee: |
| Date, Day-of-the-Week, and Time of Incident: |
| Name of Immediate Supervisor: |
| Detailed Description of Incident: |
| Has injured employee sought medical treatment for this incident? Yes No |
| If yes, give healthcare providers name and phone number: |

## SECTION II: Completion of Incident Forms (please initial each blank)

| INITIALS | |
|---|---|
| | **Employee Incident Report** completed by injured worker? |
| | All witnesses to the incident completed a **Witness Report**? |
| | Immediate supervisor completed **Supervisors Report**? |
| | **Notice to Healthcare Provider** given to injured employee? |

| | |
|---|---|
| Signature of Person Completing this Form | |
| Date Form Completed | |

***SchoolComp*** - Self Insured Workers= Compensation Program
administered by **Creative Risk Funding, Inc.**
6100 W Plano Pkwy, Ste 1500, Plano, Texas 75093
Phone 972.889.9300 Toll Free 888.230.9300 Fax 972.889.3700

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# EMPLOYEE REPORT OF INJURY INCIDENT

PRINT all information on this form.
This checklist is to be completed by the INJURED EMPLOYEE with assistance from his/her immediate supervisor as necessary.
**This packet is VERY TIME SENSITIVE.**
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the injured employee and the supervisor.
This form must be included in the Incident Investigation Packet submitted to *SchoolComp*.

## SECTION I: EMPLOYEE PERSONAL INFORMATION

| | | | | |
|---|---|---|---|---|
| First Name, Middle Initial, Last Name | | | | SS# |
| Male Female | Date of Birth (Mo, Day, Yr) | | Married | Single Divorced |
| Ethnicity: (Hispanic, Native American, Other) | | Race: Asian, Black, White | | Home Phone # |
| Home Address: | | | | Cell Phone # |
| Spouses Name: | | Email Address: | | # Dependent Children: |

## SECTION II: INJURY INCIDENT INFORMATION

| | | | |
|---|---|---|---|
| Work Location | | Job at Time of Incident | |
| Date of Hire | Work Phone # | | Best Time to Call: |
| Date of Incident (Month, Day, Year) | Day of Week (Mon, Tue, Wed....) | | Time of Day 9 AM 9 PM |
| Exact Location of Incident (Football field, classroom, cafeteria, etc. Please be specific) | | | |
| Detailed Description of Incident (In Your OWN Words) : | | | |
| Print Name of Supervisor | | | |
| Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC) | | | |
| Names of ALL Witnesses | | | |
| Did you seek treatment from a clinic, hospital, or doctor for this injury? Yes No | | | When? |
| Name of Treating Physician | | Physicians Phone # | |

I hereby certify that the above information is true and correct to the best of my knowledge. I authorize any and all providers of medical treatment deemed necessary in regard to my reported occupational injury or illness to release any medical information acquired in the course of my treatment to my employer and Creative Risk Funding, Inc.

| | |
|---|---|
| Employee Signature | Date |
| Supervisor Signature | Date |

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# WITNESS REPORT OF EMPLOYEE INJURY

PRINT all information on this form. This is to be completed by any witness to an employee injury.
This form should be completed INDEPENDENTLY, with no conversation between the witness and the injured employee.
This Witness Report is VERY TIME-SENSITIVE.
All forms in this packet should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be given to the supervisor of the injured employee for inclusion in their Incident Investigation Packet submitted to *SchoolComp*.

| Name of Injured Employee | | Name of Witness Completing Report |
|---|---|---|
| Date of Incident | Day-of-the-Week | Time of Incident: AM PM |
| Location of Incident | | |
| Specific Body Part Injured (left arm, right elbow, etc.) | | |
| Description of Injury | | |

| Detailed Description of Incident: |
|---|
| Did the employee do anything, or fail to do anything that contributed to the injury? Yes No |
| If Yes, please explain: |
| In your opinion, how could this injury have been prevented? |
| List any other witnesses that were present at the time of the injury incident: |

**I hereby certify that the above information is true and correct to the best of my knowledge. I will provide further information about this incident to my employer or Creative Risk Funding, Inc. at any time.**

| | | |
|---|---|---|
| Witness Phone Number | Number | |
| Witness Signature | Date | Printed Name |
| Supervisor Signature | Date | Printed Name |

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# IMMEDIATE SUPERVISOR REPORT OF EMPLOYEE INJURY

PRINT all information on this form.
This is to be completed by the immediate supervisor of the injured employee.
This packet is VERY TIME SENSITIVE.
The Supervisor Report should be completed the same day that the incident occurs - NOT LATER than 24 hours after the occurrence.
The completed form should be signed by the supervisor.
This form must be included in the Incident Investigation Packet forwarded to the Workers= Compensation Coordinator at the district and must be submitted to *SchoolComp*.

| Name of Injured Employee | Job Title |
|---|---|
| Date and Time this Incident was Reported to You: | |
| To what specific task was the worker assigned at the time of the incident? | |
| Was the assigned task part of the employees regular job? | |
| If NO, please explain: | |
| List safety equipment needed for this task: | |
| Was safety equipment being used by the injured worker at the time of the incident? | |

| Date of Incident (Month, Day, Year) | Day of Week (Mon, Tue, Wed....) | Time of Day AM PM |
|---|---|---|
| Exact Location of Incident (~~Football~~ field, classroom, cafeteria, etc. Please be specific) | | |
| ~~Detailed~~ Description of Incident (In Your OWN Words) : | | |
| Specific Body Part Injured: (Left leg, right hand, etc. Please be SPECIFIC) | | |
| Did the employee do anything, or fail to do anything that contributed to the injury? If yes, please explain: | | |

| | | | |
|---|---|---|---|
| Did employee lose time from work? | Yes | No | First date unable to report for work: |
| Has employee returned to work? | Yes | No | If NO, date expected to return: |
| Were District Safety Rules Violated? | Yes | No | If Yes, was Employee Counseled? |
| What steps will you take as supervisor to prevent future occurrences of this incident? | | | |

| Phone number to reach Supervisor or direct phone number for Supervisor | |
|---|---|
| Printed Name of Supervisor completing this form | Position |
| Supervisor Signature | Date |

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# IMPORTANT NOTICE TO MEDICAL PROVIDER

INSTRUCTIONS: This form should be given to the injured worker to present to the medical care provider from whom s/he seeks treatment for work-related injury. Please print all information.

**SECTION I: Incident Information**

| |
|---|
| Name of Injured Employee: |
| Date, Day-of-the-Week, and Time of Incident: |
| Specific Body Part(s) Affected by this Incident: |
| Detailed Description of Incident: |

**DEAR MEDICAL CARE PROVIDER:**
The above named employee has reported a work-related injury incident. Our district is a tax-supported public entity, and as such is Self-Insured for the purposes of Workers= Compensation. Our district DOES have a light-duty program. This may allow the injured worker to return to work with restrictions as specified by you with no lost wages to the injured employee. Please supply the injured worker with a **DWC-73 Division of Worker's Compensation Work Status Report** upon completion of initial treatment and evaluation of the injured workers= condition. Thank You.

**IMPORTANT HIPAA INFORMATION:** Since the implementation of HIPAA regulations, our district has heard concerns from a number of medical providers regarding the release of medical records without specific patient consent, even though it is clear that the information is to be used for workers= compensation utilization and billing issues. Workers= Compensation injuries are specifically excluded from HIPAA regulations, and as a result, no patient consent form is required to release medical information. (Texas Workers= Compensation Commission Advisory 2003-05)

However, as a service to medical providers, we are supplying a Release of Medical Records consent signed by the injured worker. See below. This statement, when signed by the injured worker, releases medical records to the District and Creative Risk Funding (our TPA) for the purpose of managing the claim under Texas Department of Insurance, Division of Workers' Compensation rules.

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I hereby authorize the physician/medical provider to disclose any information to my employer and employer=s agents regarding treatment for my work-related injury. I hereby release the physician/medical provider from any liability arising from such disclosure regarding this and any subsequent follow-up treatment.

| | |
|---|---|
| Employee Signature | |
| Date | |

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