Procedures for Reporting a Work-Related Injury:
Workers' Compensation Procedure

Once an employee has been injured on the job, the following steps must be taken:

- Employee must immediately inform their supervisor about the injury and report to the nearest nurse. The nurse will check on the employee's welfare and determine the severity of the injury. The nurse will provide you with an incident packet. If the nurse is not available, please refer back to your immediate supervisor.
- Fax the completed incident report to the Risk Management Department will accept the completed incident report via fax as notification.
- In case of an ***emergency*** or an ***after hour's*** injury requiring medical attention, the employee will notify the supervisor. If questions, contact ***Ernie Landeros*** at ***915- 540-9804***, and if needed, proceed to the emergency room.
- If immediate treatment is not necessary, the injury must be reported immediately to the nearest school nurse and/or supervisor. If after, you plan to seek treatment please contact the Risk Management Department at 915-434-0455.
- When medical treatment is necessary, the employee may choose one of the providers listed on the following page or to any physician who accepts workers' comp. Please refrain from treating with your private physician unless they accept workers' comp.

Procedures to follow when returning to work from a work- related injury:

Note: The following procedures apply only when an employee has been injured on the job AND has received medical treatment from a physician.

- If you are losing time from work, please notify the Risk Management Department immediately.
- Obtain a TWCC-73 Form (Release to regular or modified duty) from the treating physician or have the physician's office fax the form to the YISD Risk Management Department. (Fax Number: 915-435-9584)
- **If the physician releases the employee back to work with restrictions or completely removes him/her from work, the employee *CANNOT* return to his or her worksite. *The employee must first report to the YISD Risk Management Office for clearance.*** (During holidays, weekends, or after office hours contact **Claims Administrative Services (CAS) at 1-800-765-2412.**
- The Employee ***must*** be approved to return to work by the Risk Management Department if the employee cannot be accommodated with restrictions, the injured employee will not be allowed to report to work.
- If approved, the employee will report to the work site.

The Risk Management Offices are located at:

YISD Central Offices
9600 Sims Dr
El Paso, TX 79925
915-434-0460

When medical treatment is necessary, the employee may choose to one of the providers listed below or to any physician who accepts workers' compensation. Please refrain from treating with a private physician unless they accept workers' comp.

Eastside Rehab Med & Pain Clinic
915-593-9300; Fax 915-593-9310
*10412 Vista Del Sol, Ste 1B
El Paso, TX 79925

El Paso Orthopedic Surgery Group
915-533-7465; Fax 915-633-558
*9999 Kenworthy
El Paso, TX 79924
*1700 Murchison Dr.
El Paso, TX 79902
*3100 Lee Trevino
El Paso, TX 79935

Sun City Orthopaedic & Hand Surgery Specialists
915-581-0712, Fax 915-833-7312
*7430 Remcom Cir. Bldg 120
El Paso, TX 79912
*1400 George Dieter Dr. Ste 100
El Paso, TX 79936
*1810 Murchison, Ste 140
El Paso, TX 79902

Orthopedic Surgeons Associates
915-313-6300, Fax 915-521-2028
*4646 Mesa
El Paso, TX 79912
*1732 Weston Brent Ste F
El Paso, TX 79935

Dr. Terren Klein – Orthopedic Surgeon
915-706-2500, Fax 915-225-0110
*1300 Murchison
El Paso, TX 79902

Santa Teresa OccMed Center
575-589-5005, Fax 575-589-1333
*5055 McNutt Rd.
Santa Teresa, NM 88008

Southwest Eye Institute
915-267-2020
1400 Common Dr.
El Paso, Texas 79936

Urgent Care Centers-

(Only if urgent, otherwise please treat with any doctor on the list.)

Concentra Urgent Care
915-593-1862, Fax 915-593-2173
*1610 Zaragoza
El Paso, TX 79936
915-772-2111, Fax 915-778-6759
* 6320 Gateway Blvd. E.
El Paso, TX 79905

Upper Valley Urgent Care Center
915-584-8882, Fax 915-584-8884
*121 Redd
El Paso, TX 79932

Summit Urgent Care Center
915-857-4559
1523 N. Zaragoza Rd.
El Paso, Texas 79936

MedPost Urgent Care
(4 other locations in El Paso)
915-301-8661
9100 Viscount Blvd.
El Paso, Texas 79925

INSTRUCTIONS FOR COMPLETION OF THE WORKERS' COMPENSATION – INCIDENT REPORT

The Employee and Supervisor Incident Report must be completed in full by the employee and their immediate supervisor within **24 hours of the incident** and submitted to Risk Management via **Fax Number: 915-435-9584.**

FAILURE TO SUBMIT A COMPLETED REPORT WITHIN THE REQUIRED TIME MAY DELAY THE PROCESSING OF YOUR REQUEST FOR WORKER'S COMPENSATION BENEFITS.

If you have any question, please contact Risk Management at **434-0455.**

EMPLOYEE

1. The employee should complete the entire report in his or her own handwriting.
2. The employee is to complete the entire **EMPLOYEE** report, (**Pgs. 4 & 5**).
   Note: The employee's **and** supervisor's ***signature and date*** is required at the bottom of **pg. 5**.
3. Answer each box to avoid any delays in processing your incident report and claim. If the information requested is not applicable, please mark the box space with a notation of N/A.
4. **Box 33:** List all body parts that were injured with a description to indicate the side of the body. (i.e., right knee or left shoulder). Use another page if necessary, but remember to include all additional pages to your report.
5. **Box 37:** Read the contents of this box and place your initials on the line provided to indicate that you have read the information.
6. *Note: **Page 7** is only to be completed by the eye witness or witnesses, if applicable.*
7. Complete the **HIPPA Authorization for Disclosure of Protected Health Information**. (**Pgs. 8 & 9**).
8. Complete the **Workers' Compensation Prescription Information (Pg. 10).** *This serves as your temporary prescription card if needed.*
9. Return the completed report forms to your immediate supervisor or campus nurse.
10. A copy of the report will be given to you for your records and to present to the clinic or physician's office if you seek treatment. Page 10 of the report is for prescriptions if needed.

SUPERVISOR

11. The Supervisor report form must be completed by the employee's immediate Supervisor. (**Pg. 6**)
    Box number 29, pg. 6, requires the signature of the employee's immediate supervisor.
12. DO NOT FORGET TO FILL IN THE EMPLOYEE'S SOCIAL SECURITY NUMBER AND DATE OF REPORT located in the upper right hand corner of the form.
13. If the information requested is not applicable, please mark space with a notation of N/A.
14. The Supervisor should review the employee's report, sign and date it ensuring that all items have been properly answered.
15. The supervisor will ensure that **all** pages of the report (**Pgs. 4-10**) are completed and faxed to the Risk Management Department within 24 hours from when the incident occurred. ***(Fax: 435-9584)***

We appreciate your cooperation in completing the incident report and are available to assist you through the process.

RISK MANAGEMENT DEPARTMENT/*DEPARTAMENTO DE GESTIÓN DE RIESGOS*
FAX: 915-435-9584 AND/OR Email: elanderos3@yisd.net PHONE/*TEL*: 915-434-0455 (immediately/*inmediatamente*)

Ysleta Independent School District
Distrito Escolar Independiente de Ysleta
Worker's Compensation
Compensación del Trabajador
INCIDENT REPORT/*REPORTE DE INCIDENTE*
EMPLOYEE/*EMPLEADO*

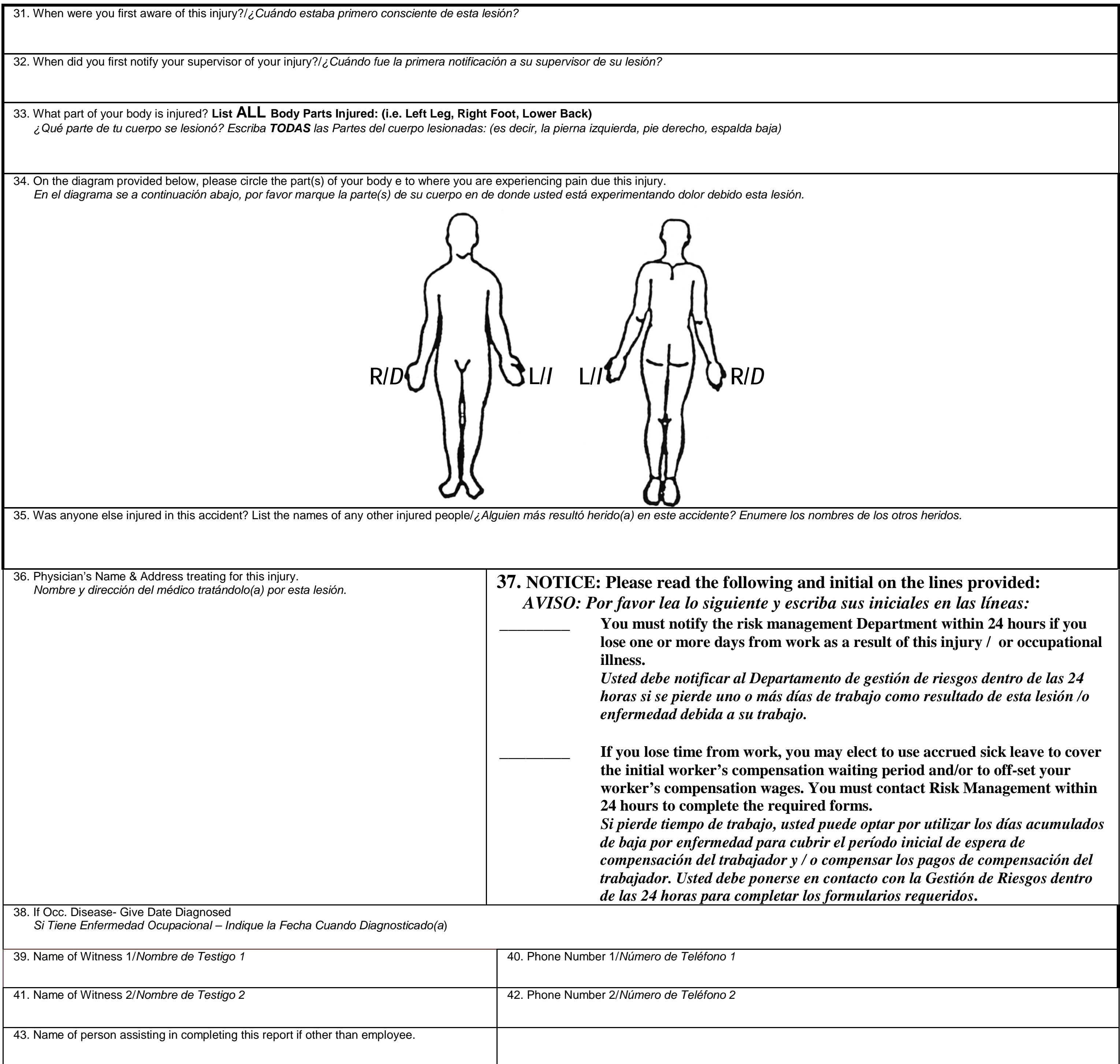
Date of Report : MM/DD/YY *Fecha de Reporte: mm/dd/aa*	Employee Social Security Number *Número de Seguro Social del Empleado*	Employee ID# *Número del Empleado*	Employee email/*Correo electrónico del Empleado*:
1. Employee Name Last First Middle: *Nombre del Empleado Apellido Primer Medio*:		2. Sex/*Sexo* ☐ Male/*Masculino* ☐ Female/*Femenino*	3. Date of Birth/*Fecha de Nacimiento*
4. Home Address/*Dirección de Domicilio* City/*Ciudad*: Zip/*Código Postal*:		5. Employee Phone # *Núm. de Teléfono del Empleado* ( ) -	6. Your Work Phone Number *Número de Teléfono de su Trabajo*

7. Race *Raza* ☐ White *Color Blanco* ☐ Black Color *Negro* ☐ Asian *Asiático*	8. Ethnicity *Origen Étnico* ☐Hispanic *Hispano* ☐Other/*Otro* ☐Native American *Americano Nativo*	9. Language Spoken/*Lenguaje Hablado* ☐ English/*inglés* ☐ Spanish/*español* ☐ Other (Specify)/*Otro (Especifique)*	10. Marital Status *Estado Civil* ☐ Married/*Casado(a)* ☐ Single/*Soltero(a)* ☐ Divorced/*Divorciado(a)* ☐ Widowed/*Viudo(a)*	11. Number of dependent Children/*Número de Hijos a su cargo*	12. Name of Spouse/*Nombre de su Esposo(a)*	
13. Date of incident: MM/DD/YY *Fecha del Incidente: mm/dd/aa*	14. Time of incident/*Hora del Incidente*	15. Day of Week Injury Occurred/*Día de la Semana Cuando Ocurrió el Incidente*	16. Date Disability began: MM/DD/YY *Fecha Cuando su Discapacidad Inicio: mm/dd/aa*	17. Last Full Day worked MM/DD/YY *Ultimo Día Completo Trabajado mm/dd/aa*	18. If Back to Work Give Date MM/DD/YY *Si Regresó al Trabajo Provea Fecha mm/dd/aa*	19. Was place of Incident on District Premises? *¿Sucedio el Incidente en las Instalaciones del Distrito*? ☐ Yes/*Sí* ☐ No
20. Campus/Division where Employed: *Plantel/División donde Trabaja:*		21. Job Title/*Título de su Puesto*		22. Date of Hire *Fecha Cuando fue Ocupado(a)*	23. Length of service in Current Position/*Cuanto Tiempo de Servicio en su Puesto Actual*	24. Length of service in occupation/*Cuanto Tiempo de Servicio en su Carrera con el Distrito*

25. Specific Location of Incident (Campus - Classroom, Hall, etc)/*Localidad Especifica del Incidente(Plantel – Aula, Pasillo, etc.)*	26. Name of Supervisor (print) *Nombre de Supervisor (letra de molde)*	27. Title of Supervisor *Título de Supervisor*	28. Supervisor's Phone Number *Numero de Teléfono de Supervisor*

29. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.) ***Use another sheet if necessary.***
¿Qué causó el incidente sucediera? (Describir completamente los hechos que dieron lugar a una lesión o enfermedad. Cuente lo que pasó y cómo pasó. Nombre objetos o sustancias que involucrados y explican cómo estaban involucrados. Dé detalles completos sobre todos los factores que causaron o contribuyeron a esta lesión o enfermedad.) Utilice otra hoja si es necesario.

30. Were you doing your normal job when incident occurred?/*¿Estaba haciendo su trabajo normal cuando ocurrió el incidente?*
☐ Yes/*Sí* ☐ No If no, then state what job you were doing, and at what location./*Si no, entonces indique cuál es el trabajo que estaba haciendo, y en qué localidad.*



31. When were you first aware of this injury?/*¿Cuándo estaba primero consciente de esta lesión?*

32. When did you first notify your supervisor of your injury?/*¿Cuándo fue la primera notificación a su supervisor de su lesión?*

33. What part of your body is injured? **List ALL Body Parts Injured: (i.e. Left Leg, Right Foot, Lower Back)**
¿Qué parte de tu cuerpo se lesionó? Escriba ***TODAS*** *las Partes del cuerpo lesionadas: (es decir, la pierna izquierda, pie derecho, espalda baja)*

34. On the diagram provided below, please circle the part(s) of your body e to where you are experiencing pain due this injury.
En el diagrama se a continuación abajo, por favor marque la parte(s) de su cuerpo en de donde usted está experimentando dolor debido esta lesión.

35. Was anyone else injured in this accident? List the names of any other injured people/*¿Alguien más resultó herido(a) en este accidente? Enumere los nombres de los otros heridos.*

36. Physician's Name & Address treating for this injury.
Nombre y dirección del médico tratándolo(a) por esta lesión.

37. NOTICE: Please read the following and initial on the lines provided:
AVISO: Por favor lea lo siguiente y escriba sus iniciales en las líneas:

_________ **You must notify the risk management Department within 24 hours if you lose one or more days from work as a result of this injury / or occupational illness.**
Usted debe notificar al Departamento de gestión de riesgos dentro de las 24 horas si se pierde uno o más días de trabajo como resultado de esta lesión /o enfermedad debida a su trabajo.

_________ **If you lose time from work, you may elect to use accrued sick leave to cover the initial worker's compensation waiting period and/or to off-set your worker's compensation wages. You must contact Risk Management within 24 hours to complete the required forms.**
Si pierde tiempo de trabajo, usted puede optar por utilizar los días acumulados de baja por enfermedad para cubrir el período inicial de espera de compensación del trabajador y / o compensar los pagos de compensación del trabajador. Usted debe ponerse en contacto con la Gestión de Riesgos dentro de las 24 horas para completar los formularios requeridos.

38. If Occ. Disease- Give Date Diagnosed
Si Tiene Enfermedad Ocupacional – Indique la Fecha Cuando Diagnosticado(a)

39. Name of Witness 1/*Nombre de Testigo 1*	40. Phone Number 1/*Número de Teléfono 1*
41. Name of Witness 2/*Nombre de Testigo 2*	42. Phone Number 2/*Número de Teléfono 2*
43. Name of person assisting in completing this report if other than employee.	

I do hereby; authorize the Ysleta Independent School District or its designee, to: (A) release any information in my personnel records; (B) obtain any personal medical records appropriate for the investigation of my claim.
Por la presente; Yo autorizo al Distrito Escolar Independiente de Ysleta o su designado, a: (A) divulgar cualquier información en mis expedientes de personal; (B) obtener cualquier historial médico personal adecuado para la investigación de mi reclamo.

____________________ Employee Signature/*Firma del Empleado*
__________ Date/*Fecha*
____________________ Supervisor Signature/*Firma de Supervisor*
__________ Date/*Fecha*

RISK MANAGEMENT DEPARTMENT
FAX: 915-435-9584
And/OR
Email: elanderos3@yisd.net
PHONE: 915-434-0455(immediately)

Ysleta Independent School District
INCIDENT REPORT
SUPERVISOR

Employee Social Security Number
Date of Report MM/DD/YY

This report is to be completed by the Principal / Supervisor of the employee.

The employee is to complete Employee Report. Both of the completed forms MUST be faxed to Risk Management within 24 hours of receiving notice of incident. Failure to comply with the deadline described above, could result in a Class "D" administrative violation of the Texas Workers' Compensation Act, Article 8308, Section 5.05. This violation may carry a fine of $25,000 per day. The appropriate school /department budget will be charged for the violation.

1. Injured Employee's Name: Last First Middle	2. Sex ☐ Male ☐ Female	3. Employee was doing regular job tasks? ☐ Yes ☐ No If No what was employee doing?	4. Was place of Incident on District Premises? ☐ Yes ☐ No

5. Date of incident: MM/DD/YY	6. Time of incident	7. Normal Starting Time on Day of Accident:	8. Campus/Division where Employed:	9. Campus/Division where Incident occurred:	10. Where Incident occurred (Classroom, Hall, etc)

11. If Back to Work Give Date MM/DD/YY	12. At same Wage? ☐ Yes ☐ No	13. Last Full Day worked MM/DD/YY	14. Date Lost Time began: MM/DD/YY	15. If Fatal injury, Give Date of Death: MM/DD/YY	16. Supervisor email:

17. What caused the incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)

18. List all parts of body injured and Nature of Injury or occupational Disease (ex. left leg, right hand,- fractures)	19. Any Property Damage? ☐ Yes ☐ No If Yes Describe:	20. Vehicle Involved? ☐ Yes ☐ No If Yes Describe:

21. If Occ. Disease- Give Date Diagnosed	22. Type of Treatment provided at site of injury ☐ None Required ☐ First Aid Only ☐ Sent to Doctor ☐ Refused Medical Treatment ☐ Other ________________________

23. What can be done to prevent this type of injury in the future?

24. Name of Witness 1	25. Phone Number 1	26. Name of Witness 2	27. Phone Number 2

28. Name/ Title of Principal / Supervisor	29. Signature of Principal / Supervisor	30. Name of Person Completing This Report If other than supervisor

Ysleta Independent School District

Workers' Compensation

Eye Witness Report of Employee Injury

(Only complete this report if you actually saw the incident)

Witness Name			
Injured Worker's Name			
Location of Incident			
Incident Date		Time of Incident	☐ AM ☐ PM
Witness Occupation			
Description of Incident (what happened and how did it happen)			
Description of Injury (body part injured and type of Injury)			
Name of other witnesses (anyone who saw or heard the incident)			

I hereby certify the above statement is true, correct and complete to the best of my knowledge and that I actually witnessed the events described above.

Witness Signature		Date
Supervisor Signature		Date

HIPAA Authorization for Disclosure of Protected Health Information

I,__________________________, date of birth ____________________, Social Security No. ______________________, authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my discretion. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):

   All healthcare providers who have provided healthcare to me.

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

   Claims Administrative Services, Inc.
   P.O. Box 7500
   Tyler, Texas 75711

   Texas Dept. of Insurance – Division of Workers' Compensation
   7551 Metro Center Drive, Suite 100
   Austin, Texas 78744-1609

   Ysleta ISD
   9600 Sims
   El Paso, TX 79925

   Others: ____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

   I further specifically authorize the disclosure of psychotherapy notes, if any.

4. The purpose for requesting this information is for the use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.

7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.

8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.

9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

____ ____________________________________

Signed Date

Name: ____

Address: ____

Telephone: __________________________ SSN: ____________________

DOB: ______________________________

[*] Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

[**] These laws apply to health plans, health care providers, and health care clearing houses.

Workers' Compensation Prescription Information

_______YSLETA ISD___________ **(employer):**

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

CAS Claims Administrative Services, Inc.
Our reputation for excellence is no accident.®

Health Innovations

Employee Name:	
Group#:	10602583
Member ID (SSN):	
Date of Injury:	
Processor:	mymatrixx
Bin#:	014211
Day supply is limited to 7 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:

Employee:

CAS has partnered with ***myMatrixx*** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain the above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.