Workers' Compensation Claims Resource Guide

2022

Texas Association of Counties
Risk Management Pool

Caldwell County courthouse.

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Introduction

Thank you for participating in the TAC Risk Management Pool Workers' Compensation program. The Pool contracts with a third party administrator, **Sedgwick**, to provide exemplary claims services for member counties and related districts. Sedgwick is a Top Tier (High Performer) in the Division of Workers' Compensation Performance- Based Oversight Audit process and is there to facilitate the claims process for you. In tandem, Sedgwick and the Pool strive to provide an easy claims reporting experience. Our goal is to ensure complete member compliance with the Texas Workers' Compensation Act. This resource guide will assist in this endeavor.

Below you will find a brief, chronological overview of employer responsibilities, including information and instructions on employer-required postings, claim forms and quick reference documents.

Before the Injury: Required Postings

- All county personnel must be notified of workers' compensation coverage. This includes employees and other personnel who the county has elected to cover (elected officials, volunteers, jurors and election workers)[1]. The prescribed ***Notice 6: Notice to Employees Concerning Workers' Compensation in Texas*** and all other notices must be posted in the human resources department and other conspicuous locations in English, Spanish and any other language common to the workplace.

- ***Notice 8: Required Workers' Compensation Coverage*** should be posted when the county contracts with any entity for building or construction services[2]. "Building or construction" refers to erecting or preparing to erect a structure, including a building, bridge, roadway, public utility facility or related appurtenance; remodeling, extending, repairing or demolishing a structure; or otherwise improving real property or an appurtenance to real property through similar activities[3].

- Applicable to law enforcement officers, firefighters, emergency medical service employees, paramedics and correctional officers, ***Notice 9: Notice Regarding Certain Work-Related Communicable Diseases and Eligibility for Workers' Compensation Benefits*** must also be posted. This notice stipulates the requirements for preliminary disease testing. As a member benefit, the Pool pays for initial testing for emergency responders.

- ***The Employer Notification of Ombudsman Program to Employees***, which is required by DWC Rule §276.5, provides an overview of the Office of Injured Employee Counsel (OIEC) and the Ombudsman program. This service is free to injured workers. Ombudsmen can assist injured workers in preparing for proceedings, attending proceedings and assisting with appeals.
- ***The First Responder Liaison Notice*** is required to notify all first responders or those who supervise volunteer first responders (EMS, peace officers and firefighters and volunteer first responders) that the OIEC has a liaison available to assist them with their disputes and claims.

When an Injury Occurs: Employee and Employer Reporting

- The injured worker must report an injury to a supervisor within **30 days** of the date it occurred. Occupational diseases (including repetitive traumas) must be reported to a supervisor within 30 days of the date the employee knew or should have known the condition was work-related. The **sample report of injury** in this guide can be completed by the injured worker as part of an internal accident investigation.
- As required by DWC Rule §120.2, members must notify the Pool within 8 calendar days of receiving notice of a work-related injury, illness or death. The ***DWC-1: Employer's First Report of Injury*** is used for this purpose.

[1] DWC Rule §110.101 (e)(1)
[2] DWC Rule §110.110
[3] Texas Labor Code§406.096(e)

- At the same time the DWC-1 is filed with the Pool, the DWC-1 must also be sent to the injured worker, along with a copy of the ***Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System***. This form can also be part of any new employee orientation. This will eliminate confusion if and when an injury occurs, and will put an injured worker at ease.

    - The Pool also asks that you provide the injured worker with a MyMatrixx flyer (pharmacy benefit management program information) and, when applicable, Alliance information (see Medical Treatment and Billing for more information on the Alliance).

Where to File Claim Forms

Members may report injuries and file all claim forms using one of the methods below:

- Online at the TAC website (Follow the link to the Sedgwick online reporting portal. A user agreement is required for a user ID and password*)
- Via email at 7937TACRMP@Sedgwick.com. This link is for reporting claims only.
- By fax at (512) 346-9321
  or phone (800) 752-6301
  *Members who do not currently have or need to update their credentials to report claims online can contact their adjuster or claims supervisor for a current user agreement form.

Reporting Wages and Work Status

- Members must send the ***DWC-3: Employer's Wage Statement*** **for all claims with lost time of 8 days or more due to the work-related injury** to ensure proper payment of Temporary Income Benefits and/or when injured workers are eligible for other types of income benefits[4]. A copy of the DWC-3 must also be provided to the injured worker. **Even though employers have 30 days after the 8th day of lost time to file the form, it is highly recommended this form is filed upon the 8th day of lost time to avoid costly overpayments and underpayments of income benefits.**
    - The injured worker may also present wages from a non-claim employer earned in the 13 weeks prior to the injury date to the adjuster on the ***DWC-3ME: Multiple Employment Wage Statement***. These wages will be combined with the DWC-3 wages and used to calculate income benefits for the injured worker. However, the adjuster will seek reimbursement from the Subsequent Injury Fund at the Division of Workers' Compensation (DWC) for the non-claim employer portion of income benefits paid.

- The ***DWC-6: Supplemental Report of Injury***[5] is required when the injured worker:

    - Returns to work or has additional disability after returning to work. The member must report these dates to the Pool **within 3 calendar days.**

    - Resigns, is terminated or is paid wages after the date of injury. Members have **10 calendar days** to report this information to the Pool.

    - A copy of the DWC-6 must also be provided to the injured worker.

    - An injured worker is responsible for reporting any wages received from other employment on the DWC-6 while receiving Temporary Income Benefits.

- Based on the county requirement to continue salary for law enforcement officers (outlined in the Texas Constitution), as a member benefit, the Pool reimburses members for what would have been paid in Temporary Income Benefits. Members may complete the ***DWC-2: Employer's Report for Reimbursement of Voluntary Payment*** and submit to the Pool to obtain reimbursement. Employers who do not report the injury timely to the Pool are not eligible for this reimbursement.

[4] DWC Rule §120.4

[5] DWC Rule § 120.3

Medical Treatment and Billing

- The Pool contracts with the **Political Subdivision Workers' Compensation Alliance, "the Alliance,"** to provide medical treatment for injured workers using evidence-based medicine for the best possible return-to-work outcomes. When a member participates in the Alliance, there is a 4% discount on workers' compensation coverage, and the injured worker is responsible for choosing a treating doctor from a list of doctors on the Alliance website at www.pswca.org. Alliance instructions, a posting and an employee acknowledgement are contained in this guide.

- In order to avoid confusion and prevent the claim from being filed with your healthcare insurance company, the injured worker can provide the "Notification of WC Coverage Provider" to his or her medical provider at the time of treatment.

- If a member chooses not to participate in the Alliance, the injured worker may choose any doctor not barred by the Division of Workers' Compensation from treating injured workers.

- We ask that you provide the treating doctor with functional temporary job descriptions (***DWC-74: Description of Injured Employee's Employment***) and work with the adjusters, treating doctors and injured workers concerning available return-to-work options.

- Treating doctors are responsible for scheduling appointments, ordering tests, providing treatment, making referrals, sending required medical reports (***DWC-73: Texas Workers' Compensation Work Status Report***) and addressing the injured worker's ability to work. Please note, the workers' compensation law prohibits the Pool from directing medical treatment.

- All medical bills pertaining to the work-related injury should be sent from the medical provider directly to the Pool's third party administrator, Sedgwick, for processing. Please ensure the injured worker presents the Notification of WC Coverage Provider when attending the initial medical appointment. This will prevent the medical provider from erroneously billing a healthcare PPO. PPOs will not release medical records without a signed medical authorization from the injured worker. This can delay treatment and inhibits medical management of the claim.

Modified Duty and Return-to-Work Procedures

When an injured worker is released to light or modified duty with restrictions, the member should make every attempt reasonably possible to provide modified work. Assistance with finding modified jobs within the county is available through the Pool's Risk Control Consultants.

A sample Bona Fide Offer of Employment in this packet complies with the requirements stipulated in DWC Rule §129.6. Before an employee returns to work on modified duty, please extend this offer and attach the DWC-73: Work Status Report. Each offer must comply with the doctor's restrictions. A Bona Fide Offer of Employment documents the acceptance or refusal of the modified work. Failure to use the offer can result in the injured worker receiving Temporary Income Benefits when modified duty is readily available at the county. For more information on Return to Work, request a copy of the *TAC RMP Return to Work Resource Guide.*

Questions?

As always, we appreciate the opportunity to serve Texas counties and related districts. Should you have any questions or suggestions concerning this document or claims reporting, please contact **Stacy Corluccio, Claims Manager**, at StacyC@county.org or (512) 478-8753, ext. 3634.

Texas Association of Counties Risk Management Pool

Workers' Compensation Contacts

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(P) 501-251-2053

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Claims Examiner
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(P) 512-427-2367

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(P) 909-942-5445

Mailing Address:

P.O. Box 160120
Austin, TX 78716

Fax Number:

512-346-9321

Pre-Authorizations

(P) 866-286-0281
(F) 877-922-7236

National Bill Review – Provider Relations

(P) 866-495-7844 or 866-366-5081
(F) 859-280-4802

Dedicated Nurse Case Manager

Mary Rankin, RN, BSHCM, CCM
Mary.Rankin@sedgwick.com
(P) 203-702-4283
(F) 201-559-4433

New Loss Reporting

Website: https://intake.sedgwick.com
Email: 7937TAC@sedgwick.com

Email for Claim Correspondence or Documents

US-YORK-tacdwcforms@sedgwick.com

ViaOne

https://viaone.sedgwickcms.net/

APPENDIX

Occupational Injury Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su Primera visita, porfavor usar este documento en cualquiera de la farmacias listadas, al reverso de este documento. Esto acelerara el procesamiento de sus recetas relacionadas con su caso aprobado de lesion en el trabajo.

¿Tiene preguntas o necesita ayuda para localizar una farmacia de la red participante? Llame al Centro de contacto de atención al paciente myMatrixx al numero 800.945.5951.

sedgwick

Name: _____

ID#: **Present at Pharmacy

Date of Injury: _____

Group #: GJC7937

Employee Date of Birth: _____

WARN ME: OPIOIDS

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Pharmacist:

myMatrixx administers this occupational injury prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $1500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx®
An Express Scripts Company

A & P	Drug Emporium	Longs Drug Store	Schnucks
Acme Pharmacy	Drug Fair	Major Value	Scolari's
Albertson's	Drug Town	Marsh Drugs	Sedano
Albertson's/Acme	Drug World	Medic Discount	Shaw's
Albertson's/Osco	Eckerd	Medicap	Shop 'N Save
Albertson's/Sav-On	Econofoods	Medistat	Shopko
Amerisource Bergen	EPIC Pharmacy	Meijer	ShopRite
Anchor Pharmacies	Network	Minyard	Snyder
Arrow	FamilyMeds	NCS HealthCare	Stop & Shop
Aurora	Farm Fresh	Neighborcare	Sun Mart
Bartell Drugs	Farmer Jack	Network Pharmaceuticals	Super Fresh
Bigg's	Food City	Northeast Pharmacy Services	Super Rx
Bi-Lo	Food Lion	Osco	Target
Bi-Mart	Fred's	P & C Food Markets	Texas Oncology Srvs
BJ's Wholesale Club	Gemmel	Pamida	The Pharm
Brooks	Giant	Park Nicollet	Thrifty White
Brookshire Brothers	Giant Eagle	Pathmark	Times
Brookshire Grocery	Giant Foods	Pavilions	Tom Thumb
Bruno	Hannaford	Price Chopper	Tops
Carrs	Harris Teeter	Publix	Ukrop's
Cash Wise	H-E-B	Quality Markets	United Drugs
Coborn's	Hi-School Pharmacy	Raley's	United Supermarkets
Costco	Hy-Vee	Randalls	Vons
Cub	Jewel/Osco	Rite Aid	Waldbaums
CVS	Kash n Karry	Rosauers	Walgreens
D&W	Keltsch	Rx Express	Wal-Mart
Dahl's	Kerr	RXD	Wegmans
Dierbergs	Kmart	Safeway	Weis
Discount Drugmart	Knight Drugs	Sam's Club	Winn Dixie
Doc's Drugs	Kroger	Sav-On	
Dominicks	LeaderNet (PSAO)	Save Mart	

POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE

Serving Public Servants

Our members are known for their service to their local communities—at city hall, the county courthouse, in schools, community centers, public utility facilities, and as first responders. If they get hurt on the job, the Alliance is here to make sure these dedicated public servants have access to top quality health care providers. We exclusively serve the members of five (5) public entity risk pools.

Injured Workers

- Find a provider
- Frequently asked questions
- Contact your adjuster

Providers

- Frequently asked questions
- Provider application
- Forms

The Political Subdivision Workers' Compensation Alliance (the Alliance) is a 504 network serving 5 public entity risk pools:

TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

IMPORTANT INFORMATION REGARDING POLITICAL SUBDIVISION WORKERS COMPENSATION ALLIANCE DO NOT DISCARD!

We are pleased that you have elected to utilize medical providers contracted by the the Political Subdivision Workers' Compensation Alliance (Alliance) to treat your injured workers. We have enclosed all the information you will need in order to start using this program.

General Instructions for Employers

1. Employee Notification

As a participating employer, you are responsible for notifying your employees about the requirement to use health care providers that are under contract with the Alliance. This can be accomplished by providing your employees a copy of the "Employee Notice of Political Subdivision Workers Compensation Alliance (Alliance) Program Requirements." A sample notice is enclosed and is also available online at www.county.org. Notice must be distributed to all employees and should be included in any new hire paperwork or during orientation.

2. Posting Notification

In addition to providing notice to each individual employee, the posting in this guide should be posted at each of your locations along with your other required postings.

3. Employee Signed Acknowledgement of Notice

Each employee must sign the "Employee Acknowledgment of the Alliance Direct Contracting Program" form that is included with the notice. The following steps below are suggested to facilitate the notice process:

i. Provide a copy or email the notice and acknowledgement form to all employees. You may distribute the notice and acknowledgement in a manner that is more electronically convenient, such as use of an intranet.

ii. Ask all employees to complete and return the acknowledgement form within a specific time frame (we suggest 7 days).

iii. If the notice will be distributed at a scheduled staff meeting or safety meeting and the signed acknowledgement forms will also be collected, have witnesses available should any employee refuse to sign the form.

iv. New employees should receive the notice and return a signed acknowledgement as part of their "new hire" process.

Documentation

Establish a standardized process as indicated above for delivery of notice and acknowledgement form that includes documenting:

- The method of notice delivery
- To whom the notice was delivered
- The location of the delivery
- The date delivered

Please retain copies of the signed acknowledgement form(s) in each employee's personnel file. An employee who refuses to sign is still subject to direct contracting requirements. All refusals should be documented in the employee's personnel file. Please do not return the signed forms to The Texas Association of Counties Risk Management Pool unless it is requested by an adjuster.

What to Do When an Injury Occurs

If appropriate, provide or arrange transportation for the injured employee to a contracted Alliance provider or, if necessary, to the nearest emergency facility.

As a reminder to the employee, you should provide the *Employee Notice of Political Subdivision Workers Compensation Alliance (Alliance) Program Requirements* (a copy is enclosed) to the injured employee at the time the injury is reported to you, or as soon as practical thereafter. The injured employee will need to sign the acknowledgement page. Please keep a copy of the signed form in your records. If necessary, your adjuster will request a copy from you.

Otherwise, you will continue with your usual procedure with regards to reporting work-related injuries. Remind the injured employee of the need to use Alliance providers and advise them how to locate a provider. You can search a list of the direct contract providers from the Alliance website at www.pswca.org. If you do not have access to the internet, please contact your adjuster at 800-752-6301 for a list of providers in your area.

NOTICE OF POLITICAL SUBDIVISION WORKERS' COMPENSATION ALLIANCE REQUIREMENTS FOR WORK RELATED INJURIES

Dear Employee:

Your employer has chosen the Political Subdivision Workers' Compensation Alliance (the Alliance) to manage the health care and treatment you may receive if you are injured at work. The Alliance includes a list of health care providers who are trained in treating work related injuries and getting people back to work safely.

When you are injured at work….

Tell your supervisor or employer immediately. For emergencies, you may go to the nearest emergency room. Otherwise, you must choose a treating doctor from the list on the web site below. Your employer will assist with any questions about how to obtain treatment. You may also contact your adjuster at the Texas Association of Counties (TAC) for any questions about treatment for a work related injury. The TAC Risk Management Fund is your employer's workers' compensation coverage provider. They work with your employer to ensure you receive timely health care. The goal is to return you to work as soon as it is safe to do so.

When you are injured, you may locate a medical provider on line at www.pswca.org.

You may contact your adjuster at the TAC Risk Management Fund at 800-752-6301.

NOTE: This is a sample document. TAC will provide an electronic copy for your use upon request.

TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

Employee Notice of Political Subdivision Workers Compensation Alliance Program Requirements

Important Contact Information

- Alliance website is www.pswca.org
- Alliance phone number is 1-866-997-7922
- To contact your adjuster call 1-800-752-6301

Information, Instructions and your Rights and Obligations

As your employer, _____<insert employer name>_____, has elected to utilize the Political Subdivision Workers Compensation Alliance (Alliance) to provide access to contracted physicians and healthcare providers for workers' compensation injuries.

If you are injured at work, tell your supervisor or manager immediately. The enclosed information will help you seek care for your injury. Also, your employer will help with any questions about how to get treatment. You may also contact The Texas Association of Counties Risk Management Pool Workers' Compensation Claims Department at 1-800-752-6301 for any questions about your care and treatment for a work related injury. TACRMP and your employer have formed a team to provide you with timely care and treatment for work related injuries. The goal is to provide quality medical care and return you to work as soon as it is safe to do so.

Injured Employees Rights and Obligations

What to do if you are injured while on the job:

If you are injured while on the job, tell your employer as soon as possible. A list of Alliance treating physicians may be available from your employer. A complete list is also available online at www.pswca.org or you may contact your adjuster directly at the following address and telephone number:

Texas Association of Counties Risk Management Pool
P.O. Box 160120
Austin, TX 78716
1-800-752-6301

In case of an emergency

If you are hurt at work, you should first notify your employer and they will assist you in locating a provider or emergency care provider.

After you receive emergency care or treatment, you may require ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available at www.pswca.org. If you do not have internet access, please call 1-800-752-6301 or contact your employer for a complete listing. The doctor you choose will oversee the care you receive for your work-related injury. Except for emergency care, you must obtain all health care and specialist referrals through your treating doctor.

Choosing a Treating Doctor

If you are injured at work you must choose a treating doctor from the Alliance panel of providers. This is **REQUIRED** for the cost of your medical care for your work related injury to be covered. A provider listing is available through the Alliance website at www.pswca.org. It is updated weekly and identifies providers who are contracted with the Alliance and accept workers' compensation patients.

If your treating physician leaves the Alliance you will be notified and you will have the right to choose another treating doctor from the list of providers. If your doctor leaves the Alliance and you suffer a life threatening or acute condition for which a disruption of care would be harmful, your doctor will contact your adjuster to request that you treat with him/her for an additional 90 days.

Changing Doctors

If you become dissatisfied with your initial choice of treating physician, you can complete the *Change of Treating Doctor Form* to select a new treating doctor from the list of Alliance providers. This form is available at www.county.org and should be completed and submitted to your adjuster for approval ***prior*** to changing doctors.

Referrals

Referrals are not required for emergency care. Your treating doctor will refer you to other health care providers if necessary for your medical treatment.

Payments for Health Care

Alliance providers have agreed to bill TACRMP for payment in relation to your health care. You should not be required to make payment at the time of your treatment. You may only access non-Alliance health care providers and remain eligible for coverage of your medical costs if one of the following situations occur:

- Emergency care is needed. You should go to the nearest hospital, urgent care, or emergency care facility
- You do not live within 75 miles of a contracted provider
- Your treating physician refers you to a non-Alliance provider or facility AND your adjuster has approved the referral prior to treatment.

Non-emergency care

Once you have selected your treating physician, your adjuster will be notified and they will contact you if additional information is required.

Complaints

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of the operation. This includes a complaint about the Alliance or an Alliance treating physician or facility. It may also be a general complaint about the PSWCA Direct Contracting Program.

Complaints should be addressed to the PSWCA Direct Contracting Program Grievance Coordinator by phone or in writing via email or fax. Complaints should be sent to:

PSWCA Direct Contracting Program
Attention: Grievance Coordinator
P.O. Box 763
Austin, TX 78767
1-866-997-7922
customerservice@pswca.org

TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

Employee Acknowledgement of PSWCA Direct Contracting Program

I have received information that informs me of my employer's election to utilize the Political Subdivision Workers Compensation Alliance (Alliance) and how to obtain health care if I should suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of contracted providers provided by my employer or obtain the list myself from www.pswca.org
2. I must go to my treating doctor for all health care related to my injury. If I need a specialist, my treating doctor will refer me. If I require emergency care I may go anywhere.
3. Making a false of fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.
4. Additional information regarding the Alliance is available on TACRMP's website at www.county.org

_____

Signature Date

_____

Printed Name

I live at _____

Street Address

_____

City, State, Zip Code

_____

Name of Employer

Please indicate whether this is the:

__Initial Employee Notification

__ Date of Injury Notification (date of injury ____/____/_____)

PLEASE RETURN THIS FORM TO YOUR EMPLOYER

Employer Rights and Responsibilities

Information for Employers from the Division of Workers' Compensation

Workers' Compensation Insurance Coverage

Workers' compensation insurance coverage provides covered employees with income and medical benefits if they sustain a work-related injury or illness. Except as otherwise provided by law; Texas private employers can choose whether or not to provide workers' compensation insurance coverage for their employees. Except in cases of gross negligence or an intentional act or omission of the employer, workers' compensation insurance limits an employer's liability if an employee brings suit against the employer for damages. Certain building or construction employers who contract with governmental entities are required to provide workers' compensation coverage for each employee working on the public project. Some clients may also require their contractors to have workers' compensation insurance.

Providing Workers' Compensation Insurance

If employers choose to provide workers' compensation, they must do so in one of the following ways:

- purchase a workers' compensation insurance policy from an insurance company licensed by the Texas Department of Insurance (TDI) to sell the coverage in Texas;
- be certified by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to self-insure workers' compensation claims; or
- join a self-insurance group that has received a certificate of approval from the TDI.

Note: Political subdivisions may self-insure, buy coverage from insurance companies, or enter into inter-local agreements with other political subdivisions that self-insure.

EMPLOYER RIGHTS

Covered employers have the following rights:

- the right to contest the compensability of a workers' compensation claim if the insurance carrier accepts liability for payment of benefits
- the right to be notified of a proposal to settl a claim or of any administrative or judicial proceeding related to resolution of a claim (after making a written request to the insurance carrier);
- the right to attend dispute resolution proceedings related to an employee's claim and present relevant evidence about the disputed issues;
- the right to report suspected fraud to the TDI-DWC or to the insurance carrier;
- the right to contest the failure of the insurance carrier to provide required accident prevention services; and
- the right to receive return-to-work coordination services as necessary to facilitate an employee's return to employment.

To dispute a workers' compensation claim, an employer may file the DWC Form-004, and the DWC Form-045, *Request to Schedule, Reschedule or Cancel a Benefit Review Conference (BRC),* which may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Non-Reimbursable Employer Payments

An employer is not entitled to and cannot seek reimbursement from the employee or insurance carrier if after a work-related injury or illness they voluntarily:

- continue to pay the injured employee's salary continuation; or
- pay the injured employee salary supplementation to supplement income benfits paid by the insuranc carrier.

Employer Voluntary Payments of Benefits

An employer may voluntarily pay income or medical benefits to an employee during a period in which the insurance carrier has:

- contested compensability of the injury;
- contested liability for the injury; or
- has not completed its initial investigation of the injury. *Note:* an employer is only allowed to pay benefits in this situation for the first two wee after the injury.

For reimbursement, the employer is required to timely report the injury to the insurance carrier and to let the insurance carrier know, within 7 days of beginning

For further assistance, call

1-800-252-7031 or visit

http://www.tdi.texas.gov/wc/employer/index.html

This publication is a summary and is presented for informational purposes only. It is not a substitute for the statute and TDI-DWC rules. For questions about TDI-DWC rules, call Customer Assistance at 1-800-252-7031. CS05-017F(1-12)

voluntary payments, that voluntary payments are being made. The insurance carrier is only required to reimburse the employer for the amount of benefits the insurance carrier would have paid. If the employer made payments in excess of what the insurance carrier would have paid, the excess amount is not reimbursable, unless there is a written agreement between the injured employee and the employer that the excess amount can be recouped from future impairment income benefits paid by the insurance carrier, if any. The employer must file the DWC Form 002, *Employer's Report for Reimbursement of Voluntary Payment*. The DWC Form-002 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

EMPLOYER RESPONSIBILITIES

Reporting Workers' Compensation Insurance Coverage to Employees

Employers must tell their employees that they carry workers' compensation insurance by providing a written notice of coverage to new employees upon hire. The written notice must inform employees of their right to reject workers' compensation coverage and retain their common law right of action. This notice must be in the wording and format prescribed by TDI-DWC's *New Employee Notice*.

Employers must also post a written notice at their place of business telling their employees that they carry workers' compensation insurance. This notice must be in the wording and format prescribed by TDI-DWC's Notice 6, *Notice to Employees Concerning Workers' Compensation in Texas*. The notice must be in English, Spanish, and any other language that is common to the employees and must be posted at conspicuous locations at the employers' place of business.

A written notice must be provided again to each employee and the Notice 6 must be updated when changes in coverage status (obtained, terminated, or canceled) occur. The TDI-DWC's *New Employee Notice* and Notice 6 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html or by calling 1-800-252-7031.

Reporting Injuries and Illnesses

Employers are required to report to its insurance carrier, within 8 days, any:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

Employers should report these injuries and illnesses using the DWC Form-001, *Employer's First Report of Injury or Illness*. An employer must keep a record of all work-related injuries, illnesses and fatalities for at least 5 years after the date the record was created, or for the period of time required by the Occupational Safety and Health Administration (OSHA), whichever is longer.

The employer must also provide a copy of the completed DWC Form-001 to the injured employee, along with a copy of the *Notice of the Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System.* The DWC Form-001 may be obtained from the TDI website at http://www.tdi.texas.gov/forms/form20employer.html. The employee's notice of rights and responsibilities may be obtained from the TDI website at http://www.oiec.texas.gov/resources/ierightsresp.html. Both forms may also be obtained by calling 1-800-252-7031.

Employer's Wage Statement & Supplemental Report of Injury

An employer must report an injured employee's wages and other fringe benefits (i.e. health premiums, uniform allowance, etc.) to the insurance carrier. The employer is required to send the DWC Form-003, *Employer's Wage Statement,* to the insurance carrier and the injured employee within 30 days of the earliest of: the date the employer is notified that the employee is entitled to income benefits; or the date of employee s death as a result of a compensable injury.

An employer must also report any changes in an injured employee's pay or employment status to the insurance carrier. The employer must send the DWC Form-006, *Supplemental Report of Injury,* to the insurance carrier and the injured employee within:

- 10 days from the end of a pay period in which an employee's pay changes;
- 10 days from the date an employee resigns or is terminated;
- 3 days from the date the employee begins to lose time from work as a result of the injury;
- 3 days from the date an employee returns to work; and
- 3 days from the date an injury causes an employee to miss additional work after returning to work.

Safe Workplace

Employers must take all actions reasonably necessary to ensure a safe workplace and take all steps reasonably necessary to protect the life, health and safety of the employees.

Compliance

Employers that fail to comply with workers' compensation requirements commit an administrative violation and may be subject to administrative penalties. The information provided in this fact sheet and workers' compensation requirements are pursuant to: Texas Labor Code §§406.002, 406.005, 406.007, 406.033, 406.034, 406.096, 408.003, 408.001, 409.011, 409.005, 409.006, 411.032, 411.103 and 413.021; and 28 Texas Administrative Code §§110.101, 120.1, 120.2, 120.3, 120.4, 126.13, 129.7 and 160.3.

If you have any questions regarding reporting requirements or compliance with the law, contact TDI-DWC at 1-800-252-7031. For more information on workers' compensation for employers, visit the TDI website at http://www.tdi.texas.gov/wc/employer/index.html.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] _____ Texas Association of Counties Risk Management Pool. In the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] Texas Association of Counties Risk Management Pool _____. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

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EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

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Call the Division of Workers' Compensation at 1-800-252-7031 or access the division's website at www.tdi.texas.gov/wc/indexwc.html to receive information on the legal requirement for coverage, to verify whether your employer has provided the required coverage, or to report an employer's failure to provide coverage.

TO THE EMPLOYER/CONTRACTOR:

Pursuant to Workers' Compensation Rule 110.110 (d)(7), a contractor engaged in a building or construction project for a government entity is required to post a notice on each project site informing all persons providing services on the project that they are required to be covered by workers' compensation insurance. The notice required by this does not satisfy other posting requirements imposed by the Texas Workers' Compensation Act or other Workers' Compensation Rules. This notice must:

(1) be posted in English, Spanish and any other language common to the employer's employee population;
(2) be displayed on each project site;
(3) state how a person may verify current coverage and report failure to provide coverage;
(4) be printed with a title in at least 30-point bold type and text in at least 19-point normal type; and
(5) contain the exact words as prescribed in Rule 110.110 (d)(7).

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Act and Workers' Compensation Rules. The violator may be subject to administrative penalties.

DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE DISEASES AND ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

TO: LAW ENFORCEMENT OFFICERS, FIRE FIGHTERS, EMERGENCY MEDICAL SERVICE EMPLOYEES, PARAMEDICS, AND CORRECTIONAL OFFICERS

In order to qualify for workers' compensation benefits, an employee who claims a possible work-related exposure to a reportable disease, including HIV infection, must be tested for the disease not later than the 10th day after the exposure and must provide their employer with documentation of the test and a sworn affidavit of the date and circumstances of the exposure. The test result must indicate the absence of the disease. The employee is not required to pay for the test.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of State Health Services. Exposure criteria and testing protocol must conform to Texas Department of State Health Services requirements.

TO: ALL STATE EMPLOYEES

In order to qualify for workers' compensation benefits, a state employee who claims a possible work-related exposure to human immunodeficiency virus (HIV) infection, must be tested for HIV within 10 days after the exposure and must provide their employer with documentation of the test and a written statement of the date and circumstances of the exposure. The test result must indicate the absence of HIV infection. The employee is not required to pay for the test.

For additional information: Talk to your employer or call the Division of Workers' Compensation at 1-800-252-7031. Also, contact the Texas Department of State Health Services (DSHS) to ensure full compliance with the Health and Safety Code and DSHS rules.

EMPLOYERS OF EMERGENCY MEDICAL SERVICE EMPLOYEES, PARAMEDICS, FIRE FIGHTERS, LAW ENFORCEMENT OFFICERS OR CORRECTIONAL OFFICERS:

Pursuant to Workers' Compensation Rule 110.108, employers of emergency medical service employees, paramedics, fire fighters, law enforcement officers or correctional officers must post a notice informing employees about requirements contained in the Health and Safety Code which could affect qualifying for workers' compensation benefits following a work-related exposure to a reportable communicable disease. This notice must:

1) be posted in the employer's personnel office, if any;
2) be posted in the workplace where employees are likely to read the notice on a regular basis
3) be printed with a title in at least 15 point bold type and the text in at least 14 point normal type
4) contain the text as set out in rule 110.108(d)
5) be posted in English and Spanish, or in English and any other language common to the employee's affected employee population.

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Texas Workers' Compensation Act and Division rules and may subject the violator to administrative penalties.

The cost of testing for exposure to a reportable communicable disease shall be paid by the employer's workers' compensation insurance carrier.

STATE AGENCIES:

Pursuant to Workers' Compensation Rule 110.108 each state agency must post a notice informing employees about requirements which may affect qualifying for workers' compensation benefits following a work related exposure to human immunodeficiency virus (HIV). The notice must:

1) be posted in the agency's personnel office;
2) be posted in the workplace where employees are likely to read the notice on a regular basis
3) be printed with a title in at least 15 point bold type and the text in at least 14 point normal type
4) contain the text as set out in rule 110.108(d)
5) be posted in English and Spanish, or in English and any other language common to the employee's affected employee population.

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Texas Workers' Compensation Act and Division rules and may subject the violator to administrative penalties.

The cost of testing for exposure to a reportable communicable disease shall be paid by the employer's workers' compensation insurance carrier.

DO NOT POST THIS SIDE

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-393-6432. More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.

CONNECT @OIEC @OIECTexas @OIECtube oiec.texas.gov

Figure 28 TAC §276.5(c) - April 2018

AVISO PARA LOS EMPLEADOS SOBRE LA ASISTENCIA DISPONIBLE EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES POR PARTE DE LA OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

¿Se ha lesionado en el trabajo? Como empleado lesionado en Texas, usted tiene derecho a recibir asistencia gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés). OIEC es la agencia estatal que asiste a los empleados lesionados que no cuentan con representación legal con su reclamación en el sistema de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando a su número de teléfono gratuito: 1-866-393-6432. Más información sobre OIEC y sobre el Programa de Ombudsman se encuentra disponible en el sitio web de la agencia (www.oiec.texas.gov).

PROGRAMA DE OMBUDSMAN

¿QUÉ ES UN OMBUDSMAN? Un Ombudsman es un empleado de OIEC que le puede asistir si usted tiene una disputa con la aseguradora de su empleador. La asistencia por parte del Ombudsman es gratuita. Cada Ombudsman cuenta con una licencia de ajustador de compensación para trabajadores y ha completado un extenso programa de capacitación, el cual ha sido diseñado específicamente para asistirle a usted con su disputa.

Un Ombudsman puede ayudarle a identificar y desarrollar los asuntos en disputa en su caso e intentar resolverlos. Si los asuntos no pueden ser resueltos, el Ombudsman puede ayudarle a solicitar un procedimiento de resolución de disputas ante el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation, por su nombre en inglés). Una vez que el procedimiento ha sido programado, el Ombudsman puede:

- Ayudarle a prepararse para el procedimiento (Conferencia para Revisión de Beneficios [Benefit Review Conference, por su nombre en inglés] y/o Audiencia para Disputar Beneficios [Contested Case Hearing, por su nombre en inglés]);
- Asistir al procedimiento con usted y hablar en su nombre; y
- Ayudarle con una apelación o con una respuesta a la apelación de una aseguradora, si es necesario.

OFFICE OF INJURED EMPLOYEE COUNSEL

NOTICE REGARDING FIRST RESPONDER LIAISON TO ASSIST IN WORKERS' COMPENSATION DISPUTES

TO: First Responders

The Office of Injured Employee Counsel (OIEC) is the state agency that assists, educates, and advocates on behalf of the injured employees of Texas.

OIEC has a designated employee who is the liaison for first responders. The liaison is highly trained as an ombudsman and in the rights of first responders within the workers' compensation system.

As a first responder, you can call (512) 804-4173 or email firstresponderhelp@oiec.texas.gov for help with your workers' compensation claim.

You can contact OIEC by calling its toll-free telephone number: 1-866-393-6432. More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

CONNECT @OIEC @OIECTexas @OIECtube oiec.texas.gov

Figure 28 TAC §276.5(d) - April 2018

OFICINA DE ASESORÍA PÚBLICA PARA EL EMPLEADO LESIONADO

AVISO REFERENTE A INTERMEDIARIO PARA EMPLEADOS DE RESPUESTA INMEDIATA PARA AYUDAR EN LAS DISPUTAS DE COMPENSACIÓN PARA TRABAJADORES

PARA: Empleados de Respuesta Inmediata (First Responders, por su nombre en inglés)

La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel –OIEC, por su nombre y siglas en inglés) es la agencia estatal que asiste, educa, y aboga en nombre de los empleados lesionados en Texas.

OIEC cuenta con un empleado que ha sido designado como intermediario para los empleados de respuesta inmediata. El intermediario está altamente capacitado como ombudsman y también está capacitado en los derechos de los empleados de respuesta inmediata dentro del sistema de compensación para trabajadores.

Como empleado de respuesta inmediata, usted puede llamar al (512) 804-4173 o enviar un correo electrónico a firstresponderhelp@oiec.texas.gov para recibir ayuda con su reclamación de compensación para trabajadores.

Usted puede comunicarse con OIEC llamando al número de teléfono gratuito: 1-866-393-6432. Más información sobre OIEC y su Programa de Ombudsman está disponible en el sitio web de la agencia (www.oiec.texas.gov).

CONÉCTESE @OIEC @OIECTexas @OIECtube oiec.texas.gov

Título 28 Código Administra o de Texas §276.5(d) - Abril 2018

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ Social Security:_____ Gender: M / F
Last First MI Maiden

Address:_____ Date of Injury: _____

City: _____ State: _____ Employer:_____

Primary Phone Number: _____ Job Title: _____

Secondary Phone Number: _____ Work Schedule:_____

Email address: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date_____ Time_____

Name: _____ Title_____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone:_____

Name _____ Phone: _____ Name:_____ Phone:_____

7) Please identify your Primary Care Physician or family doctor: Name:_____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name:_____ Phone: _____

Name:_____ Phone:_____

Name:_____ Phone: _____

9) Has a doctor taken you off work? ___Yes ___ No If so, when was the first day you missed work ?_____

10) If the doctor took you off work, have you returned to work? ___Yes ___No If not, when do you think you will return to work?_____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ___Yes ___No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature:_____ Date:_____

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

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 filing.**

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. 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 filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. 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 filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

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? YES ☐ NO ☐	If No, Specify Language	
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? YES ☐ NO ☐	28. Supervisor's Name	29. Date Reported (m-d-y) - -

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		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box	Telephone ( )	43. Business Location (If different from mailing address) Number and Street	
City	State Zip Code	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.
48. Workers' Compensation Insurance Company Texas Association of Counties RMP		49. Policy Number	

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 _____

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.**

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):			Employer's Business Name:		
Employee's Mailing Address (Street or P.O. Box):			Employer's Mailing Address (Street or P.O. Box):		
City:	State:	ZIP Code:	City:	State:	ZIP Code:
Social Security Number: XXX-XX-			Federal Tax I.D. Number:		
Date of Hire:	Date of Injury:		Name and Phone # of Person Providing Wage Information:		

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on _____ and is working:
☐ without restriction. **OR**
☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us/wc/rules/.

WAGE INFORMATION INSTRUCTIONS

Employee Name: Social Security #: Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits**.

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

Texas Department Of Insurance
Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-93
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#

Carrier Claim#

Send the completed form to the TDI-DWC field office handling the claim.

EMPLOYER'S CONTEST OF COMPENSABILITY (DWC Form-004)

The employer has the right to contest the compensability of an employee's injury if the insurance carrier accepts liability for the payment of benefits. The employer may contest compensability of a claim after presenting the grounds for non-compensability to the carrier and giving the carrier the opportunity to contest compensability. [Texas Workers' Compensation Act §409.011]

1. Employee's Name (Last, First, M.I.)	**2. Social Security Number** (last four digits) xxx-xx-
3. Date of Injury (mm/dd/yyyy)	**4. Employer's Name** (Last, First, M.I.)
5. Employer's Mailing Address (Street or P.O. Box, City, State, Zip)	
6. Employer's Telephone No.	**7. Insurance Carrier**
8. Provide any relevant facts supporting the reason(s) for contesting compensability.	

TDI-DWC Date Stamp Here

Employer's Signature _____ **Date** _____

Title _____

If you have questions about this form, contact staff at your local TDI-DWC Field Office at 800-252-7031.

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

CLAIM # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name | 2. Employer phone #

3. Employer mailing address

4. Insurance carrier name

5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
If so, identify contact person and phone # _____ _____

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name | 12. SSN (last 4 digits) XXX-XX- | 13. DOI

14. Injured worker mailing address and phone #

15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | 16. First day of additional lost time or reduced wages (mm/dd/yyyy)

17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
date of resignation _____ date of termination _____ date of death _____
19a. Reason for resignation/termination _____
19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐

20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week

21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____

Indicated hours are:
☐ Increase from pre-injury
☐ Same as pre-injury
☐ Decrease from pre-injury

Indicated wages are:
☐ Increase from pre-injury wage
☐ Same a pre-injury wage
☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

_____ _____
Signature and Title of person completing this form | Date

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker **is** entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER)** are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

This report must be filed in the following situations within the timeframes indicated:
- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:
- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
7551 METRO CENTER DRIVE, SUITE 100
AUSTIN, TEXAS 78744

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S REPORT FOR REIMBURSEMENT OF VOLUNTARY PAYMENT (DWC Form-002)

1. Employer's Name		13. Employee's Name (Last,First, M.I.)
2. Employer's Mailing Address (Street or P.O. Box)		14. Employee's Mailing Address (Street or P.O. Box)
City State Zip Code		City State Zip Code
3. Federal Tax I.D. No.		15. Employee's Social Security Number
4. Date of Injury	5. Date of this Notice	16. Name of Insurance Carrier
6. Date Lost Time Began	7. Date of Initial Payment	17. Address of Insurance Carrier (Street or P.O. Box)
8. Amount of Payment $ **$**	9. Number of Weeks Paid	City State Zip Code
10. From	11. To	18. Address of Insurance Carrier Claims Office (Str. or P.O. Box)
12. This Payment: ☐ Initiates Compensation ☐ Supplements Injured Employee's Income ☐ Covers Medical Expenses Incurred		City State Zip Code 19. Insurance Carrier Representative

The employer should notify Texas Department of Insurance, Division of Workers' Compensation and the insurance carrier within 7 days after the date of initial payment. An employer who fails to timely file the report of injury or occupational disease as required by Section 409.005, of the Texas Workers' Compensation Act waives the right to reimbursement of any voluntary payments and may be assessed an administrative penalty. If there is a dispute concerning reimbursement of any employer's payments of compensation or medical benefits, the employer may file a subclaim in accordance with Section 409.009, of the Texas Workers' Compensation Act.

The insurance carrier should reimburse the employer within 7 days after receiving the request and should notify the Texas Department of Insurance, Division of Workers' Compensation within 7 days of payment of the amount and date of the reimbursement.

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Notification of WC Coverage Provider

To whom it may concern:

_____ is covered by The **Texas Association of Counties Risk Management Pool** for compensable workers' compensation injuries that occur in the coverage period from ___/___/___ to ___/___/___. The Pool contracts with Sedgwick to adjust its claims. All medical bills (excluding pharmacy), reports and other supporting documentation may be submitted to the following address for consideration:

TAC Risk Management Pool
P.O. Box 160120
Austin, TX 78716

800.752.6301
512.346-9321 (fax)

US-YORK-tacdwcforms@sedgwick.com

Please note, all bills are subject to retrospective review, reconsideration, and preauthorization under the Texas Workers' Compensation Act.

With the exception of emergency treatment, if the county participates in the Political Subdivision Workers' Compensation Alliance (Alliance), the treating doctor must be chosen from a list of Alliance doctors located at www.pswca.org. Please contact your adjuster at the number above for additional information.

Texas Department Of Insurance
Division of Workers' Compensation
7551 Metro Center Dr., Ste.100
Austin, TX 78744-1609
(512) 804-4000 (512) 804-4378 fax www.tdi.texas.gov

Treating Doctor Name
Treating Doctor Telephone Number
Treating Doctor Fax Number
Treating Doctor E-mail

DESCRIPTION OF INJURED EMPLOYEE'S EMPLOYMENT (DWC Form-074)

Send the completed DWC Form-074 to the requestor. Do not send a copy to TDI-DWC.

I. CONTACT INFORMATION

1. **Injured Employee Name** (First, Last, M.I.)	2. **Date of Injury** (mm/dd/yyyy)	3. **Social Security Number** (last four digits) xxx-xx-
4. **Employer Name**	5. **Employer Mailing Address**	
6. **Employer Telephone Number**	7. **Name of employer's contact person**	
8. **Employer contact person's schedule** (availability to speak to the doctor)	9. **Employer contact person's telephone number**	
10. **Employer contact person's fax number**	11. **Employer contact person's e-mail address**	

II. DESCRIPTION of the injured employee's job functions and duties, specific tasks, work activities and physical responsibilities, at time of injury. To be completed by employer representative who has knowledge of the injured employee's job.

1. **Employee's Occupation/Job Title**

2. Would you, the employer, consider providing modifications to current job, as described above, including schedule changes, part-time work, and reduced production requirements, as well as providing alternate work assignments in accordance with the treating doctor's instructions? ☐**Yes** ☐**No** (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

3. **POSTURE**

Max Hours per day:	**0 2 4 6 8**
Standing	☐☐☐☐☐
Sitting	☐☐☐☐☐
Kneeling/Squatting	☐☐☐☐☐
Bending/Stooping	☐☐☐☐☐
Pushing/Pulling	☐☐☐☐☐
Twisting	☐☐☐☐☐

4. **MOTION**

Max Hours per day:	**0 2 4 6 8**
Walking	☐☐☐☐☐
Climbing stairs/ladders	☐☐☐☐☐
Grasping/squeezing	☐☐☐☐☐
Wrist flexion/extension	☐☐☐☐☐
Reaching	☐☐☐☐☐

Max Hours per day:	**0 2 4 6 8**
Overhead reaching	☐☐☐☐☐
Keyboarding / mouse	☐☐☐☐☐
Driving	☐☐☐☐☐

5. **LIFT/CARRY REQUIREMENTS**
☐ Lifts or carries objects weighing _____ lbs. _____ x per day, week or month _____
☐ Performs no lifting/carrying

6. **TOOLS/EQUIPMENT OR MACHINERY**

Frequency of use	**N/A**	**Occasional**	**Frequent**	**Constant**
Hand tools, manual	☐	☐	☐	☐
Hand tools, power	☐	☐	☐	☐
Fork lift / other heavy machinery	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

7. **ENVIRONMENT**

Frequency of exposure (hours per day)

	0 2 4 6 8		**0 2 4 6 8**
Heat	☐☐☐☐☐	Noise	☐☐☐☐☐
Cold	☐☐☐☐☐	Other	☐☐☐☐☐
Vibration	☐☐☐☐☐	_____	

8. **Additional information** (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Employers may be eligible for reimbursement for expenses they incur to return employees to work. Information about the Employer Return-to-Work Reimbursement program is available at http://www.tdi.texas.gov/wc/rtw/.

9. **Date description of employment requested**	10. **Date sent to treating doctor/requestor**

DWC074 Rev.09/09

Instructions for Completing
DESCRIPTION OF INJURED EMPLOYEE EMPLOYMENT (DWC Form-074)

What is the purpose of the DWC Form-074, *Description of Injured Employee Employment*?

The purpose of the form is to facilitate the exchange of information between the employer and injured employee's treating doctor regarding the job functions and duties, specific tasks, work activities and physical responsibilities of an injured employee's job at the time of injury and return the injured employee to employment as soon as it is considered safe and appropriate by the treating doctor.

Who should complete the DWC-074?

The form should be completed by an employer representative who has actual knowledge of the injured employee's job requirements, job functions and physical responsibilities.

Where does the employer send the completed form?

The employer should send the completed DWC Form-074 to the treating doctor or originating requestor. The employer should retain a copy of the completed form for their records. *Do not send a copy of the completed DWC-Form 074 to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC).*

Does completing the DWC Form-074 constitute a request to return to work, a job offer, or an admission of compensability?

No, by completing and returning the DWC- Form 074 to the treating doctor or originating requestor, the employer is not making a request to return to work, a job offer, or admitting compensability.

Can the employer provide additional information along with the DWC Form-074 in responding to a request for description of an injured employee's employment?

Yes, when completing the DWC Form-074, the employer is encouraged to provide additional information that they would like the treating doctor to consider in Box 8, including information about the job the employee had at the time of the injury, and also any other jobs that the employer may have to offer. The employer may attach a job description identifying job functions and physical responsibilities or any other related documentation to the form.

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under Texas Government Code §552.021 and §552.023 of the Texas Government Code, you are entitled to receive and review the information. Under §559.004 of the Texas Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call your local TDI-DWC field office at 800-252-7031.

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

1. Injured Employee's Name		5. Doctor's Name and Degree	(for transmission purposes only) Date Being Sent
2. Date of Injury	3. Social Security Number (last 4) xxx-xx-	6. Clinic/Facility Name	9. Employer's Name
4. Employee's Description of Injury/Accident		7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)
		8. Clinic/Facility/Doctor Address (street address) City State Zip	11. Insurance Carrier
			12. Carrier's Fax # or Email Address (if known)

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date).

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):		17. MOTION RESTRICTIONS (if any):		19. MISC. RESTRICTIONS (if any):
Max Hours per day: 0 2 4 6 8	Other	Max Hours per day: 0 2 4 6 8	Other	☐ Max hours per day of work: _____
Standing ☐☐☐☐☐		Walking ☐☐☐☐☐		☐ Sit/Stretch breaks of _____ per _____
Sitting ☐☐☐☐☐		Climbing stairs/ladders ☐☐☐☐☐		☐ Must wear splint/cast at work
Kneeling/Squatting ☐☐☐☐☐		Grasping/Squeezing ☐☐☐☐☐		☐ Must use crutches at all times
Bending/Stooping ☐☐☐☐☐		Wrist flexion/extension ☐☐☐☐☐		☐ No driving/operating heavy equipment
Pushing/Pulling ☐☐☐☐☐		Reaching ☐☐☐☐☐		☐ Can only drive automatic transmission
Twisting ☐☐☐☐☐		Overhead Reaching ☐☐☐☐☐		☐ No work / _____ hours/day work: ☐ in extreme hot/cold environments ☐ at heights or on scaffolding
Other: ☐☐☐☐☐		Keyboarding ☐☐☐☐☐		☐ Must keep _____ ☐ elevated ☐ clean & dry

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Left Leg
☐ Right Hand/Wrist ☐ Right Leg
☐ Left Arm ☐ Back
☐ Right Arm ☐ Left Foot/Ankle
☐ Neck ☐ Right Foot/Ankle

Other:

Other:

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than _____ lbs. for more than _____ hours per day

☐ May not perform any lifting/carrying

Other:

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No running

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)

☐ Advised to take over-the-counter meds

☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm

☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm

☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm

☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm

☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
			☐ Initial	☐ Designated doctor	☐ Carrier-selected RME
Discharge Time			☐ Follow-up	☐ Treating doctor	☐ DWC-selected RME
				☐ Referral doctor	☐ Other doctor
				☐ Consulting doctor	

Frequently Asked Questions
Work Status Report (DWC Form-073)

Under what circumstances am I required to file the DWC Form-073?
Filing requirements for DWC Form-073 vary depending on the type of doctor filing the Work Status Report. The specific requirements are shown in the chart below.

Type of Doctor	When to File DWC Form-073	Where to File	Delivery Method	Deadline
Treating Doctor or Referral Doctor	• after the initial examination of the injured employee, regardless of the employee's work status • when there is a change in the injured employee's work status • when there is a substantial change in the injured employee's activity restrictions • on a schedule requested by the insurance carrier as long as it is based on the injured employee's scheduled appointments with the doctor (not to exceed one report every two weeks)	• injured employee	hand deliver	at the time of the examination
		• insurance carrier	fax or e-mail	within 2 working days of the examination
		• employer	fax or e-mail unless recipient has not provided these numbers; then by personal delivery or mail	
	• after receiving a set of functional job descriptions, from the employer or insurance carrier listing modified duty positions, including the physical and time requirements of the positions, that the employer has available for the injured employee to work • after receiving a DWC Form-073 from a RME Doctor that indicates the injured employee is able to return to work with or without restrictions	• injured employee	hand deliver unless no appointment is scheduled before deadline; then fax or e-mail unless recipient has not provided these numbers; then by mail	within 7 days of receiving job description or RME opinion
		• insurance carrier • employer	fax or e-mail	
Designated Doctor	• after examination of an injured employee to address any question relating to return to work **NOTE:** The Designated Doctor must file a narrative report along with the DWC Form-073.	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 working days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
		• TDI-DWC	fax to 512-490-1047	
RME Doctor selected by insurance carrier	• after examination of an injured employee (subsequent to a Designated Doctor's examination), if the RME doctor determines that the injured employee can return to work immediately with or without restrictions	• injured employee • injured employee's representative (if any)	fax or e-mail unless recipient has not provided these numbers; then by other verifiable means	within 7 days of the examination
		• insurance carrier • treating doctor	fax or e-mail	
RME Doctor selected by DWC	Not applicable. TDI-DWC's medical examinations are ordered in accordance with §408.0041, Texas Labor Code, and applicable Division of Workers' Compensation rules.			

Where can I find more information about the DWC Form-073?
For complete requirements regarding the filing of this report, see 28 TAC §§126.6, 127.10, and 129.5. These rules are available on the TDI website at www.tdi.texas.gov/wc/rules/index.html. If you have additional questions, call *Comp Connection for Health Care Providers* at 1-800-372-7713 (804-4000 in the Austin area) and select option 3.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Bona Fide Offer of Employment
Sample Instructions to the Employee

PLEASE FOLLOW THE INSTRUCTIONS BELOW:

1. Read the attached letter carefully. If this letter is not clear please contact our office immediately for clarification.
2. Please check the appropriate space below indicating acceptance or denial of the offer of employment.
3. Sign and date the form.
4. Return the letter immediately. A phone call may be made to accept or not accept the position. Refusal to accept the bona fide job offer may affect your temporary income benefits.

SAMPLE BONA FIDE OFFER OF EMPLOYMENT

(Date)

(Employee name)

(Address 1)

(Address 2)

Re: Bona Fide Offer of Employment

Dear (Employee name):

After reviewing the information provided by your doctor, we are offering you the following temporary work assignment.

This assignment is within your capabilities as described by your doctor on the attached Work Status Report (DWC-73). You will only be assigned tasks consistent with your physical abilities, skills, and knowledge and if any training is required to perform this assignment, it will be provided.

Position title: _____

Description of physical requirements of this position: _____

_____

Location: _____

Duration of assignment: From: (_____) To: (_____)

Work Hours: From: (_____) To: (_____)

Wages: _____(Hour, Week, Month)

Department: _____ Supervisor:_____

This job offer will remain open for seven (7) calendar days from your receipt of this letter. If you do not respond within seven (7) calendar days, we will presume you have refused this offer. Refusing this offer may impact your income benefits.

We look forward to your return. If you have any questions, please do not hesitate to contact me (include phone number or email address).

Sincerely,
(Signature)
(Typed name and title)

EMPLOYEE:

_____ I have read and understand the requirements of the position and accept the position.

_____ I have read and understand the requirements of the position but do NOT accept the position.

_____ _____

Employee's Signature Date Signed

USEFUL WEBSITES

http://www.tdi.texas.gov/forms/form20.html (DWC Forms and Notices)

http://www.tdi.texas.gov/wc/indexwc.html (DWC Home page)

http://www.tdi.texas.gov/wc/employer/index.html (DWC Resources for Employers)

http://www.oiec.texas.gov/ (Office of Injured Employee Counsel Web site)

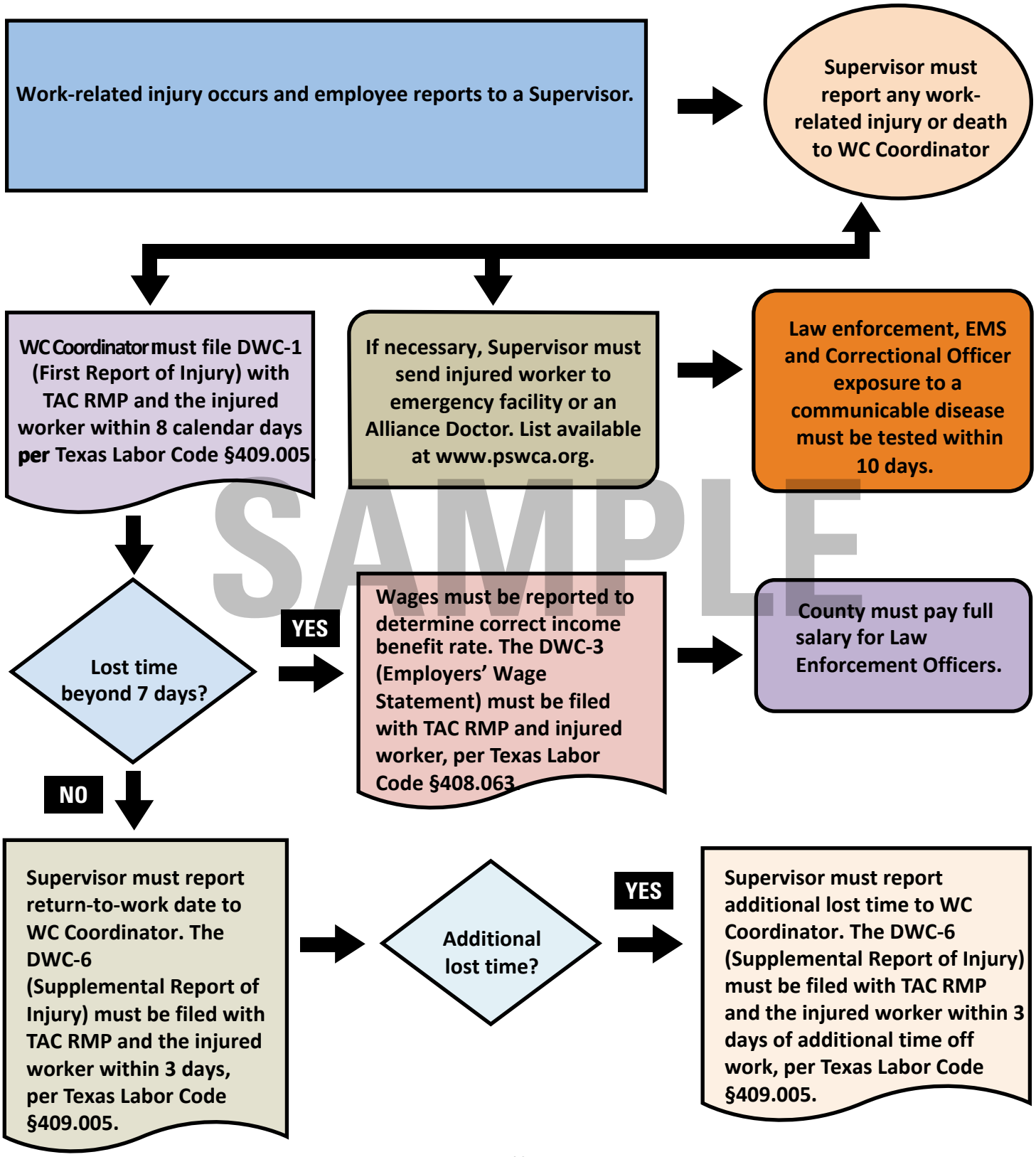
https://www.iclaimsexpert.com/apps/ice/cow/icowlogin.r?brand=jic (York Risk Services Group injury reporting portal)

http://www.tdi.texas.gov/wc/rtw/index.html (DWC Return to Work Resources)

http://www.mathematica-mpr.com/our-publications-and-findings/projects/return-to-work-policy-collaborative (Office of Disability Employment Policy: Stay at Work/Return to Work)

www.pswca.org (Political Subdivision Workers' Compensation Alliance)

Workers' Compensation Injury and Claim Reporting Process



Workers' Compensation Injury and Claim Reporting Details

An injured worker must report an on-the-job injury to a supervisor or someone acting in a supervisory capacity within 30 days of the injury or within 30 days of the date the injured worker knew or should have known about an occupational illness.[1]

When an injury is reported, the employer is required to report it to the TAC RMP on the **DWC-1**, First Report of Injury, form within 8 calendar days[2]. Failure to file this form timely or properly can result in an Administrative Violation for the county in the event of an audit or complaint.

Depending on the severity of the injury, the supervisor should assist the injured worker with medical treatment. The injured worker may treat with a doctor or his or her choosing or must treat with an Alliance doctor if the county makes the Alliance mandatory for its employees. The provider list is located at www.pswca.org. Please ensure that the injured worker notifies his or her medical provider of the work-related incident to avoid medical bill filing with a healthcare insurance company.

Communicable Diseases and Required Testing

If the injured worker is a law enforcement officer, EMS employee, paramedic, fire fighter or correctional officer, and is exposed to any of the following communicable diseases, he or she is required to be tested for the following communicable diseases[3] within 10 days of the exposure.

"Acquired immune deficiency syndrome (AIDS); amebiasis; anthrax; botulism--adult and infant; brucellosis; campylobacteriosis; chancroid; chickenpox; Chlamydia trachomatis infection; cholera; cryptosporidiosis; dengue; diphtheria; ehrlichiosis; encephalitis; Escherichia coli 0157:H7; gonorrhea; Hansen's disease (leprosy); Heamophilus influenzae type b infection, invasive; hantavirus nfection; hemolytic uremic syndrome (HUS); hepatitis, acute viral; human immunodeficiency virus (HIV) infection; legionellosis; listeriosis; Lyme disease; malaria; measles (Rubeola); meningitis; meningococcal infection, invasive; mumps; pertussis; plague; poliomyelitis, acute paralytic; rabies in man; relapsing fever; Rocky Mountain spotted fever; rubella (including congenital); salmonellosis, including typhoid fever; shigellosis; streptococcal disease, invasive Group A; syphilis; tetanus; trichinosis; tuberculosis; tuberculosis infection in persons less than 15 years of age; typhus; Vibrio infection; viral hemorrhagic fevers; and yellow fever."

This list of diseases may change from time to time. To determine the most current list of reportable diseases and exposure criteria, refer to Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases.

Full Salary for Law Enforcement Officers

According to Texas Constitution Article 3 Section 52e, an opinion by the Texas Attorney General regarding detention officers, an appellate court's opinion regarding a specific case as presented by detention officers, and a Supreme Court opinion, counties are obligated to continue full salary for an injured law enforcement official.

Employee Resignation or Termination

The county is also required to report when an employee is terminated or resigns. The county has 10 days after the termination or resignation date to file a **DWC-6, Supplemental Report of Injury**, with the TAC RMP and the injured worker [4].

1 Texas Labor Code §409.001
2 Texas Labor Code §409.005
3 Division of Workers' Compensation Rule §122.3
4 DWC Rule §120.3

QUICK REFERENCE GUIDE: DWC Forms and Postings

	County	TAC RMP	Injured Worker
DWC-1: Employer's First Report of Injury	The county must complete and send this form to TAC RMP and the injured worker no later than **8 calendar days** after receiving notice of an injury, occupational illness or a fatality.	The DWC-1 is used to make contacts for the initial claims investigation. The DWC-1 may also be used to compute Temporary Income Benefits for injured workers in the absence of the DWC-3: Employer's Wage Statement.	The injured worker must complete the DWC-41, not the DWC-1, within 1 year of the date of injury and send to the Division of Workers' Compensation (DWC) at the Texas Department of Insurance.
Employee Rights and Responsibilities Notice	This document must be provided to the injured worker at the same time the DWC-1 is filed.	This form is located in the Member ResourceGuide and on the website of the Office of Injured Employee Counsel	Injuries must be reported within 30 days to a supervisor. Occupational illnesses must be reported no later than 30 days from the date the employee knew or should have known the illness was work-related.
myMatrixx Form (pharmacy benefit management)	Provide this form to the injured worker along with the DWC-1.	This form is located in the **WC Claims Resource Guide.**	The injured worker must complete this form to ensure proper dispensation of any prescribed medications.
Alliance Participation Information	If your county makes the Alliance mandatory, provide the Alliance acknowledgement documents to the injured worker when the DWC -1 is filed. Be sure to collect the Employee Acknowledgement.	Alliance information is located in the WC Claims Resource Guide. A list of Alliance doctors is located on their website at www.pswca.org.	Injured workers must complete the Employee Acknowledgement and choose a doctor from the Alliance list to ensure medical bills are paid.
DWC-3: Employer's Wage Statement	This form must be sent to TAC RMP and the injured worker no later than **30 days after the injured worker's 8th day of disability** (inability to earn pre-injury wages).	TAC RMP uses this form to compute all income benefits. *When the form is received soon after or on the 8th day of disability, unnecessary overpayments and underpayments are avoided.*	The injured worker must receive the Employer's Wage Statement at the same time it is filed with TAC RMP.
DWC-6: Supplemental Report of Injury	This form is required **within 3 days** when the injured worker returns to work or has additional disability after returning to work, and **no later than 10 days after the end of a pay period** when the injured worker is earning more or less than preinjury wages, resigns or is terminated. It must be sent to TAC RMP and the injured worker.	TAC RMP uses this form to stop, start and reduce Temporary Income Benefits.	The injured worker must complete this form to report wages when he or she is no longer working for the county.
DWC-2: Employer's Report for Reimbursement of Voluntary Payment	This form may be used to request reimbursement from TAC RMP for salary continuation of law enforcement officials.	TAC RMP reimburses counties for salary continuation of law enforcement officials only. The amount of the reimbursement is limited to what would have been paid to the injured worker for Temporary Income Benefits.	This form only applies to law enforcement officials as defined by Labor Code, Article 3, Section 52e of the Texas Constitution.
DWC-4: Employer's Content of Compensability	The county may dispute liability for a claim after TAC RMP has investigated and accepted the claim. This form is filed with the DWC Field Office.	TAC RMP has 15 days after notice of an injury to complete an initial investigation.	This form does not have to be filed with the injured worker.

DWC Form Reporting Instructions

The DWC-1 may be reported to Sedgwick:

- Online (Sedgwick online portal)*
- Via email: US-YORK-tacdwcforms@sedgwick.com or
- Fax: (512) 346-9321

The DWC-3 and DWC-6 may be reported to Sedgwick:

- Online (Sedgwick online portal)*
- Via email: mailto:US-YORK-tacdwcforms@sedgwick.com or
- Fax: (512) 346-9321

**Employers must have a login and password to access online claims reporting. For more information, please contact Trenisha.Bryant@sedgwick.com (512) 427-2415.*

DWC Postings and Records that are required of Employers

DWC Notice 6	DWC Notice 8**	DWC Notice 9	Office of Injured Employee Counsel (OIEC) Notice
Notice to Employees Concerning Workers' Compensation in Texas This posting provides the name of the Workers' Compensation coverage provider. It also contains information regarding injured workers' injury reporting responsibilities, Office of Injured Employee Council contact information, and the DWC Safety Violations Hotline. The Notice must be posted in English and Spanish and other languages common to the employer's employee population. It must be posted in the personnel office and where employees frequent. TAC RMP recommends posting in the employee break rooms and restrooms.	**Required Workers' Compensation Coverage** This notice should be posted when the county employs general and subcontractors for building and construction. It states that all who work on the site must be covered by workers' compensation insurance. The Notice must be posted in English and Spanish and other languages common to the employer's employee population. It must be posted on each project site.	**Notice Regarding Certain Work-Related Communicable Diseases and Eligibility for Workers' Compensation** This posting pertains to law enforcement officers, fire fighters, emergency medical service employees, paramedics, and correctional officers. It states that these employees must be tested within 10 days after an exposure to a communicable disease, including HIV. This notice must be posted in English and Spanish and any other language common to the county's employee population, in the personnel office, if any, and where employees are likely to read it on a regular basis.	**Employer's Notice of Ombudsman Program** This posting informs the injured worker of the existence of the OIEC and its Ombudsmen, who provides free claims assistance to unrepresented injured workers. The notice must be posted in the personnel office, if any, and in the workplace where each employee is likely to see it on a regular basis. It must be posted in English, Spanish, and any other language that is common to the employer's employees.

****TAC RMP recommends posting DWC Notice 8 due to the potential for high exposure claims which may occur during construction projects.**

DWC Rule 120.1 requires all employers to keep a record of injuries 5 years from the last day of the year in which the injury occurred or the time required by OSHA, whichever is greater. The record includes the same information that is captured in the DWC-1 Form. The records must be open to inspection by the Division of Workers' Compensation upon at least 5 working days' notice to the employer, at a reasonable time and place. Administrative penalties for failure to maintain or make a record available may be assessed up to $500.

Workers' Compensation Injury Checklist

Below is an abbreviated checklist which summarizes the county responsibilities when reporting an injury and ensures compliance with the Texas Labor Code. Refer to the WC Claims Resource Guide for additional information on responsibilities before and after an injury has been reported.

When an Injury Occurs…

☐ Review the county internal accident investigation and/or the **Employee Report of Injury**. Interview the employee concerning the facts of the accident.

☐ Complete the **Employer's First Report of Injury (DWC-1) form**. Do not ask the injured worker to complete this form. The DWC-1 is an employer-required form.

Report the Injury to the TAC RMP

☐ Send the **DWC-1** to the TAC RMP within 1 day of the injury.

- You may email to US-YORK-tacdwcforms@sedgwick.com. Or, fax the form to (512) 346-9321.
- You may also report injuries online with credentials and training. For a user ID and password, contact Trenisha.Bryant@sedgwick.com.

Items for the Injured Worker

☐ Send the **DWC-1** and the following documents to the injured worker.

☐ **MyMatrixx Flyer** (serves as a temporary prescription card)

☐ **Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System** brochure

☐ If the county participates in the Alliance, be sure to review all the Alliance information in the WC Claims Resource Guide and make sure the employee signs the **Employee Acknowledgement of PSWCA Direct Contracting Program**

Communication with the Medical Provider

☐ Ensure the provider is aware the accident is/was work-related. **The TAC RMP Notification of WC Coverage Provider** can be used for this purpose.

☐ When you have modified duty available, send the **Description of Injured Employee's Employment (DWC-74)** form to the treating doctor. The doctor has 7 days to respond with a **Texas Workers' Compensation Work Status Report (DWC-73)** form indicating if an injured worker can return to work with or without restrictions.

Questions concerning this document or injury reporting? Contact StacyC@county.org at (512) 478-8753, ext. 3634.

Lone Star County Workers' Compensation Telemedicine Program

Injured employees can choose to see a doctor via Telemedicine by calling:

888-REDIMD5 (733-4635)

24/7 Telemedicine Services for

Lone Star County

Works with: Smart Phone, Tablets/I-pads, Computer with a Webcam and Internet connection

If you have any additional questions, please contact

Zamayra Cantu at 888-733-4635

zcantu@redimd.com

P.O. Box 2131 • Austin, Texas 78768
(512) 478-8753 • (800) 456-5974 • county.org