Worker's Compensation

When an injury/accident occurs at work an employee is entitled to file Worker's Compensation. When the incident occurs, please make sure that Ashley Young is immediately notified of the incident at 903-381-2295. *All incidents must be reported, even if the employee is not seeking medical attention or planning to file Worker's Comp.*

The employee will need to complete the Employee Accident Report and the Employee's Election Regarding Utilization of Sick Leave. These forms will need to be completed and sent to the Business Office within 24 hours. The forms can be emailed to ayoung@lisd.org or faxed to (903) 381-4001. The originals will need to be sent over to the Business Office. The employee should also be given information regarding their rights, and a worker's compensation prescription form. ***Failure to submit the forms in a timely manner can leave the district open to fines and penalties ranging from $500-25,000 per day.*** The principal or supervisor will need to complete an accident investigation report. The investigation should be completed within 24 hours of the incident.

If the employee requires medical treatment the employee may see any doctor that accepts Worker's Compensation insurance. The following clinics listed below are the approved clinics in this area:

Healthcare Express (Preferred Prov)
1509 W. Loop 281
Longview, TX 75605
(903) 759-9355

LOMC
3202 N. Fourth St. Ste 100
Longview, TX 75605
(903) 757-0577

CSS Healthcare
121 Gilmer Rd.
Longview, TX 75604
(903) 232-7144

Please note, if the incident requires immediate attention please seek treatment at the nearest facility or provider.

ACCIDENT INVESTIGATION PLAN

Each work-related accident should be investigated immediately (within 24 hours) after the occurrence. A systematic method should include the following:

- Visit the scene of the accident
- Take digital pictures as needed
- Interview the injured employee(s)
- Interview any witnesses
- Interview the supervisor
- Reconstruct chain of events leading up to the accident

In addition, the investigation should include a description of the following:

- Accident type or event that caused the injury (slip, trip or fall .. etc.)
- Part of body directly affected by the injury
- Unsafe conditions or equipment that caused or contributed to the accident
- Unsafe acts that caused or contributed to the accident
- Other related factors or elements that may have contributed to the accident

Once all the facts and information concerning the accident have been obtained, the following questions should be addressed to prevent similar type incidents form happening in the future.

- Can the unsafe condition be fixed, repaired, or eliminated?
- Can the unsafe equipment be fixed or replaced?
- Does the employee need post-accident safety training or disciplinary action?
- Are any changes needed in existing operations or procedures?

The purpose of accident investigation is to find the causes and recommend corrective action to eliminate or minimize these events. All accidents should be investigated and the emphasis on finding facts, not finding fault.

LONGVIEW INDEPENDENT SCHOOL DISTRICT
EMPLOYEE ACCIDENT REPORT

Revised 11/07

The injured employee should complete this form. Lost time because of the injury should be reported immediately to the Supervisor and the Business Office.

Employee #	Name (Last, First, M.I.)		
Sex F / / M / / SS #	Date of Birth	Home Phone	
Does Employee Speak English? Yes / / If no, Specify Language			
Ethnicity White / / Black / / Hispanic / / Other / /			
Mailing Address			
City	State	Zip Code	County
Marital Status	# of Dependent Children	Spouse Name	
Did employee go to doctor? Yes / /	No / /		
Doctor Name and Address			
Date of Injury	Time of Injury	AM / / PM / / Lost Time Began	
Type of Injury			
Part of Body Injured or Exposed (include Left or Right)			
How and Why Injury Occurred			
Was Employee doing his/her regular job? Yes / / No / / Occupation			
Worksite Location of Injury (stairs, classroom, etc)			
Campus Name and Address			
List of Witnesses			
Signature of Employee	Date		
/ / I HAVE RECEIVED A COPY OF THE EMPLOYEE RIGHTS AND RESPONSIBILITIES.			
I have reviewed this form with the injured employee and the statements are true and correct to the best of my knowledge. Signature of Principal/Supervisor	Date		

ACCIDENT INVESTIGATION REPORT

TO BE COMPLETED BY PRINCIPAL OR SUPERVISOR
Turn in to Business Office within 48 hours of accident

1. Name of injured: _____ Job title: _____

2. Injury date: ____/____/_____ Time: _____ Medical care: Yes _____ No _____

3. Accident location: _____ Room/Area: _____

4. Type of Injury: _____ _____
(Body parts) (Signs/Symptoms)

5. What was the injured doing at the time of the accident? _____
(What happened to cause accident?)

_____

_____

6. Equipment, tool(s), materials in use: _____

_____

7. Protective gear used: _____

_____

8. Findings of investigation: _____
(Was the employee negligent? – Is safety equipment or retraining needed to prevent injury?)

_____

_____

_____

9. Name(s) of witnesses: _____

10. Witnesses description of events leading up to the accident: _____

_____

_____

_____

11. Supervisors Signature/Date _____

Take pictures of any unsafe condition or equipment involved in accident.

TO THE INJURED EMPLOYEE: PLEASE READ CAREFULLY

This is a Workers Compensation Claim Form.

Longview Independent School District's Workers Compensation Plan is Self-Funded which means that the district pays 100% of the cost of your claim. No insurance company provides coverage for these costs in any way.

The district uses Longview Occupational Medical Clinic at 3202 N. Fourth Street Suite 100 and Healthcare Express at 1509 W. Loop 281, Longview, TX for non-emergency treatment. **LOMC nor Healthcare Express will not treat you unless an Authorization for Treatment is faxed to them from the Business Office.**

Please call the Business Office at **903-381-2200** to inform of the injury and an authorization will then be faxed.

Any additional medical treatment must be approved by Claims Administrative Services at 1-800-765-2412.

If the injury is a life-threatening injury, please call 911. Please have someone call the Business Office immediately to report the injury and give specific information on the injury. Do not call 911 unless the injury is life-threatening.

Do not pay for your medical service and/or prescriptions. The provider should mail the claim to Claims Administrative Services, PO Box 7500, Tyler, Tx 75711

Do not present your Health Insurance card to providers of medical services or prescriptions related to this injury.

As provided by State law, if an employee misses work due to an injury, LISD's workers compensation plan will pay benefits beginning on the 8th calendar day of lost time. However, an employee may elect to take sick leave, if available, for the first 7 days.

On the 8th calendar day of lost time, LISD's workers compensation plan will begin paying your lost time at 70% of your wages. The employee may also elect sick leave, if available, to make up the 30% difference in wages.

Benefits cease under the plan when the employee is released by their doctor.

EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK LEAVE AS IT RELATES TO WORKMANS COMPENSATION BENEFITS

(Refer to Board Policy on Insurance and Annuities Management: Workers Compensation)

_____ **Election 1**

I hereby elect to use workers' compensation and sick leave proportionately to reach 100% of my current salary. By making this election, I understand that my sick leave will automatically be used to pay the 7 day waiting period and then proportionately thereafter.

_____ **Election 2**

I hereby elect to receive weekly payments of workers' compensation and only use sick leave for the seven day waiting period. No other sick leave will be used after the seven day waiting period is over.

_____ **Election 3**

I hereby elect to only receive weekly payments of workers' compensation after the seven day waiting period. I understand that I am waiving my rights to use any sick leave during the seven day waiting period as well as proportionately thereafter.

_____ _____

Employee Signature Date

_____

Print Employee Name Social Security Number

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. 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. This is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

Your Rights in the
Texas Workers' Compensation System

1. **You may have the right to receive benefits.**
   You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:
   - You were intoxicated at the time of the injury;
   - You injured yourself on purpose or while trying to injure someone else;
   - You were injured by another person for personal reasons;
   - You were injured by an act of God;
   - Your injury occurred during horseplay; or
   - Your injury occurred while voluntarily participating in an off-work activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit for this medical care.**

3. **You have the right to choose your treating doctor. If you are in a Workers' Compensation Health Care Network, you can choose your doctor from the network's treating doctor list. If you are not in a network, you can choose a doctor from the Approved Doctor List kept by the Division of Workers' Compensation.**
   It is important to follow all the rules in the workers' compensation system. If you don't follow these rules, you may be held responsible for payment of medical bills.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**
   Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432).

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**
   An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of workers' compensation and provide free assistance to injured employees without attorneys. Ombudsmen cannot sign documents for you, make decisions for you or give legal advice. Proceedings about your claim may include benefit review conferences (BRCs) or contested case hearings (CCHs). Proceedings are held at local field offices. At least one ombudsman is located in each local office.

7. **You have the right for your 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 the Division of Workers' Compensation.

(SEE REVERSE SIDE FOR RESPONSIBILITIES)

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

Your Responsibilities in the
Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.**
   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. Your employer must give you a copy of the Texas Department of Insurance network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel.
   If you would like to file a complaint about a network, call the Consumer Help Line at 1-800-252-3439.
   Or file a complaint on the Internet at: www.tdi.state.tx.us/consumer/complfrm.html#wc

3. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

4. **You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. 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 DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation.
   Call toll-free 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

5. **You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.**

6. **You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:**
   - You stop working because of your injury;
   - You start working; or
   - You are offered a job.

(SEE REVERSE SIDE FOR RIGHTS)

Contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). More information is available on the Internet at: www.oiec.state.tx.us.

Contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division is available on the Internet at: www.tdi.state.tx.us/wc/indexwc.html.

DWC PUB. NO. CS06-007A(6-06)

PHARMACY: FIRST FILL CARD FORM

Claims Administrative Services, Inc. has partnered with myMatrixx, a leading pharmacy benefit manager, to make filling your workers' compensation prescription(s) easy and at no cost to you.

EMPLOYEE

1. If you need a prescription filled for a work-related injury or illness, go to a participating pharmacy.
2. Give this form to the pharmacist.
3. The pharmacist will fill your prescription at no cost to you.

This is for a one-time prescription fill. If your workers' compensation claim is accepted, a permanent card will be mailed to you in the next 3-5 business days. Questions? Please call myMatrixx: 877-804-4900 or visit the website at: www.mymatrixx.com.

PHARMACIST

1. Please obtain information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections, please call myMatrixx: 877-804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance. *NOTE: Certain medications are pre-approved for this patient. Pre-approved medications will process without an authorization. All others will require prior approval.*

EMPLOYER

1. Please fill out the information in the First Fill Prescription Card and provide the employee with this form to take to any pharmacy.

Most pharmacies and all major chains are included in our network. Contact us if you need assistance locating a participating pharmacy near you, call:

myMatrixx: 877-804-4900

FIRST FILL PRESCRIPTION CARD	
Employee Name	
Employer	
Rx BIN	014211
Processor	myMatrixx
Group #	10602583
Member ID (SSN)	

Supply is limited to 7 days for a new injury. myMatrixx good medicine for business

EXAMPLES OF PARTICIPATING PHARMACY CHAINS (NOT A COMPLETE LIST)

Albertson's	Fred Meyer	Hy-Vee	Lifechek Drug	Price Chopper	Schnuck's	Tops Pharmacy
BJ's Pharmacy	Fred's	Ingles	Long's Drug	Price Cutter	Shopko	USA Drug
Costco	Fry's Pharmacy	Kaiser Permanente	Medicap	Publix	ShopRite	U-Save
Cub Pharmacy	Genovese	Kerr Drug	Medicine Shoppe	Raley's	Smith's	Vons
CVS Health	Giant Eagle	King Soopers	Meijer	Randall's	Snyder's Drugs	Walgreens
Dominick's	Hannaford Foods	Kinney Drugs	Navarro Discount	Reasor's	Stop & Shop	Walmart
Drug Emporium	Happy Harry's	Kmart	Neighbor Care	Rite Aid	Super D	Wegmans
Duane Reade	Harris Teeter	Kroger	Osco	Safeway	Super Rx	Weis Pharmacy
Eagle Pharmacy	H.E.B.	Leader Drug	Pathmark	Sam's Club	Target	Winn Dixie
Eaton Apothecary	Homeland	Lewis Pharmacy	Piggly Wiggly	Sav-On	Tom Thumb	Yokes

LOMC

950 N Fourth Street
Longview, Tx 75604

FAX to (903) 753-1087

Authorization To Treat

Date: _____ **Social Security No:** _____

Employee: _____ **Employer:** ___**Longview ISD**_____

Person Authorizing Service:_____ **Company Phone:** _903-381-2200_____

☐ **Work Related Injury Treatment**
(additional form required)

Physical Examination:

☐ Pre-placement Medical Exam

☐ DOT Certification Exam
(check type of test if drug screen is needed)

Medical Testing:

☐ Audiometric Testing

☐ PFT/Spirometry

☐ Chest X-ray ☐1 view ☐ 2 view

☐ Lumbar Spine X-ray ☐1-2 view ☐3 view

☐ Vision Screening

☐ Other: _____

Lab Testing:

☐Complete Blood Count (CBC)

☐Blood Lead Level

☐TB Skin Test

☐Other: _____

☐ **Drug Screen Testing**

Reason:

☐ Pre-Employment ☐ Post Accident ☐ Random

☐ Reasonable Suspicion

****PHOTA ID IS REQUIRED FOR TESTING****

Type of Test:

☐ Non DOT ☐ DOT ☐ Onsite

☐ Breath Alcohol ☐ Blood Alcohol

☐ Hair Testing

Vaccination:

☐ Hepatitis Series ☐ Flu ☐ Tetanus

☐ Other: _____

Special Instructions: _____

_____

_____

HealthCARE Express
Urgent Care & Occupational Medicine
PUTTING THE CARE BACK IN HEALTHCARE.

Request to Test or Treat

Company Name: _____

Employee name: _____

Employee Id or SS #: _____

Date: _____ **Time:** _____

This is a: ❑DOT Procedure ❑Non-DOT Procedure

Please perform the following procedure for the above employee for:

❑ Breath Alcohol

❑ Urine Drug Test ❑Hair Test ❑Nail Test ❑Quick Test (all positives will be sent to lab for confirmation)

❑Physical ❑Bus Driver Physical ❑PFT ❑FIT ❑Audio ❑X-Ray

❑Flu Shot ❑Hep B Shot ❑TB Skin Test ❑Hepatitis Titer ❑ Work Related Treatment

❑ Other _____

The reason for Testing is:

❑Pre-employment ❑Random ❑Post-Accident ❑Reasonable Suspicion

❑Return to Duty (must be observed) ❑Follow-up (must be observed)

❑Other _____

DER or Authorized Name: _____

DER or Authorized Signature: _____

Phone Number: _____

121 Gilmer Rd.
Longview, Texas 75604
Office: 903-232-7144
Fax: 903-232-7160
www.csshealthcare.net

Send Authorization to longview@csshealthcare.net or fax to 903-232-7160

Company Name:_____ Phone:_____
Person Authorizing :_____
Patient Name:_____ Date of Birth_____

Emergency Services

- ☐ Work Related Injury
  Date of Injury _____

Insurance Company/ Claim #

_____
_____
_____

DOT Physical

- ☐ Recertification
- ☐ Pre-employment

Physical:

- ☐ Non-DOT Physical
- ☐ Return to Duty Physical
- ☐ Fit for Duty
- ☐ Hazmat

Other Services:

- ☐ Immunizations _____
- ☐ Pulmonary Function Test (PFT)
- ☐ Audio
- ☐ Vision Screening
- ☐ ZPP
- ☐ Lead
- ☐ X-ray
- ☐ Other_____

Quantitative Fit Test

- ☐ ½ face
- ☐ Full Face

Mask Type:_____

Qualitative Fit Test

- ☐ ½ Face

Mask Type:_____

Drug Screens:

- ☐ DOT Drug Screen (circle agency)
  FMSCA FAA FRA FTA
  PHMSA USCG

- ☐ Non DOT drug screen
- ☐ Instant 10 panel
- ☐ Hair
- ☐ Oral Fluid Testing

If you have marked a drug screen you must mark a reason for the screening

- ☐ Post- Accident
- ☐ Random
- ☐ Pre-Employment
- ☐ Pre-Access
- ☐ Reasonable Suspicion

Breath Alcohol:

- ☐ DOT
- ☐ Non-DOT

If you checked this box you must mark a reason for BAT

- ☐ Post- Accident
- ☐ Random
- ☐ Pre-Employment
- ☐ Pre-Access
- ☐ Reasonable Suspicion

NIOSH

- ☐ PFT
- ☐ X-ray