

LONGVIEW ISD

WORKER'S COMPENSATION

When an injury/accident occurs at work an employee is entitled to file Worker's Compensation. After the incident occurs, please notify Trisha Broughton immediately at (903) 446-2455 or (903)381-2200. If after hours, please call (903)576-0948 for authorization.

All incidents must be reported, even if the employee is not seeking medical treatment or planning to file Worker's Compensation.

The employee will need to complete the Employee Accident Report and the Employee's Election Regarding Utilization of Sick Leave. The principal or supervisor will need to complete an accident investigation report. All completed forms including the investigation will need to be sent to the Business Office within 24 hours of the incident. Please email to tbroughton@lisd.org or fax to (903) 381-4001. The original will need to be sent 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.

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 approve clinics in this area:

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

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

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

Nova Medical
1111 N. Sixth St
Longview, TX 75601
(903) 522-4111

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 from 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

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: _____ ID# _____ DOB: _____

Sex: F / M SS# _____ Phone Number: _____

Does the Employee Speak English? Yes / No If no, specify language _____

Ethnicity: White / Black / Hispanic / Other / _____

Mailing Address: _____

Marital Status: _____ # Dependent Children: _____ Spouse Name: _____

Date of injury: _____ Time of Injury: _____ AM / PM

Does the employee require medical treatment? Yes / No Type of Injury: _____

How and Why Injury Occurred: _____

Part of Body Injured or Exposed (include Left or Right) _____

Was Employee doing his/her regular job? Yes / No

Campus: _____ Occupation: _____

Location of Injury (stairs, classroom, etc): _____

Witnesses: _____

___ I have received a copy of the employee rights and responsibilities

Signature of Employee

Date

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 PRINCIPLE 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: _____

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

Supervisor's Signature: _____ Date: _____

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 Healthcare Express, Nova Medical, Longview Occupational and CCS Healthcare for work related injuries.
 - **You will not be treated unless an Authorization for Treatment has been faxed to the treating facility from the Business Office.**
 - Please call Trisha Broughton at 903-446-2455 or Business Office at 903-381-2200 to report 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**. Someone must notify 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.
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Do not pay for your medical service or prescriptions. All worker's comp claims should be submitted 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. Please refer to the Benefit Election Form for additional compensation options.

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

Longview Independent School District

Employee Election to Use Paid Leave with Workers' Compensation Benefits

Name: _____

Employee ID# _____

Position: _____

Department/Campus: _____

Date of Injury: _____

This employee is absent from duty because of a work-related illness or injury beginning on _____. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

Please select and complete at least one of the following. This information must be completed as you are confirming that the employee will receive full pay during this time and there will be no loss of wages.

- A. _____ # of days of leave available OR
- B. _____ # of hours of leave available OR
- C. The date that available leave will expire on is: _____

District Authorized Signature

Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

_____ I choose to use only _____ days of available paid leave at this time.

_____ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wages. I further understand that my leave will continue to be used unless and until I communicate to the district a change in my decision.

_____ I choose NOT to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Longview ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, after exceeding seven days of lost time, unless and until I communicate to the district a change in my decision.

Employee Signature

Date

»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

»» To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 7-day supply or a cost of \$500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

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

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: ____/____/____
MM/DD/YYYY

Group #: PAWA _____

Employee Date of Birth: ____/____/____

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 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



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