WORKERS' COMPENSATION INSURANCE

ADMINISTRATIVE PROCEDURE AND MANAGEMENT STANDARD GUIDE

For

THE TEXAS A&M UNIVERSITY SYSTEM

(Consisting of the Following Members)

Texas A&M University System Offices

Texas A&M University

Tarleton State University

Prairie View A&M University

Texas A&M University - Corpus Christi

Texas A&M University-Galveston

Texas A&M University - Kingsville

Texas A&M International University

West Texas A&M University

Texas A&M University – Commerce

Texas A&M University - Texarkana

Texas A&M University – Central Texas

Texas A&M University – San Antonio

Texas AgriLife Research

Texas AgriLife Extension Service

Texas Forest Service

Texas A&M AgriLife

Texas Engineering Experiment Station

Texas Engineering Extension Service

Texas Transportation Institute

Texas A&M University System Health Science Center/Baylor College of Dentistry

Texas A&M University System
Risk Management
Revised 5/10

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FOREWORD

The Texas A&M University System Workers' Compensation Insurance Program was created by the 52nd Legislature of the State of Texas to provide reasonable and necessary medical coverage and disability payments to employees who sustain injuries or occupational disease while in the course and scope of their employment. The program statutory authority is embodied in Chapter 502 of the Texas Labor Code. Funding for this self-insured program is provided through an assessment against the total payroll of each System member. All costs associated with the program, including payments to employees and administrative expenses, are paid from these funds.

Direct administration of the Workers' Compensation Insurance Program is provided by the Director of Risk Management who, along with the Workers' Compensation Manager, coordinates the program throughout The System, establishes uniform system-wide procedures, standards, and record keeping criteria, and acts as the liaison with other State of Texas agencies, including the Texas Department of Insurance, Division of Workers' Compensation (TDI, DWC or DWC).

The following procedures and management standards clarify certain administrative and legal requirements of The Texas A&M University System Workers' Compensation Insurance Program and the rules promulgated by the Texas Department of Insurance, Division of Workers' Compensation, the agency charged with monitoring all workers' compensation programs in the State of Texas.

A monetary penalty may be assessed against a member by The Texas Department of Insurance, Division of Workers' Compensation for failing to comply with the procedures and standards in this guide.

I. WHAT IS WORKERS' COMPENSATION INSURANCE?

Workers' Compensation Insurance is a form of insurance specifically designed to provide medical payments and, in some cases, financial payments to employees on the payroll of The Texas A&M University System who suffer injuries, occupational diseases, or work related death in the course and scope of their employment.

In instances of injury or illness, the employee is entitled to all medical aid, hospital services, and medication reasonably required at the time of injury and anytime thereafter to cure and relieve the effects naturally resulting from the injury.

In some instances, financial payments will be available to offset a temporary loss of earning capacity and/or to compensate for permanent impairment due to the injury.

Workers' Compensation is not health insurance, a benefit program, nor does it provide compensation for damage to or loss of personal property.

OUT OF STATE COVERAGE

The Texas A&M University System self-insured WCI Program based on chapter 502 of the Texas Labor Code may provide coverage for employees hired and working out of the State of Texas. An employee who performs services outside this state is entitled to benefits under this chapter even if the person:

1) Is hired or not hired in this state.
2) Does not work in this state.
3) Works both in this state and out of state.
4) Is injured outside this state.
5) Has been outside this state for more than one year.

In some states we may be required to purchase workers' compensation insurance coverage. For questions please contact System Risk Management.

II. WHAT ARE THE RESPONSIBILITIES OF THE EMPLOYING MEMBER OR AGENCY

Each member within The Texas A&M University System has responsibilities to the injured employee, to System Risk Management, and to the Texas Department of Insurance, Division of Workers' Compensation (TDI,DWC).

A. Responsibilities to the injured employee include:

(1) Notifying the injured employee that his or her injury may be covered under the workers' compensation program.

(2) Arranging for appropriate medical treatment in emergency situations. **Keep in mind that the injured employee has the right to select his or her own treating physician.** It is inappropriate to force the employee to see a health care provider if the employee does not want medical attention.

Please do not request that the employee get a second opinion from a particular physician. Requests for second opinions will be handled by the System Office of Risk Management.

If a health care provider calls for pre-authorization to treat the injured worker, refer the provider to System Office of Risk Management. It may be necessary to assure the provider that the injured worker is covered by workers' compensation insurance. Please use the following statement in these instances:

"I can confirm that The Texas A&M University System is self-insured for workers' compensation. Employees of The Texas A&M University System who are injured in the course and scope of employment are entitled to reasonable and necessary medical treatment which will be covered and paid for in compliance with Texas Department of Insurance, Division of Workers' Compensation regulations."
It is not appropriate to "guarantee" payment for services.

(3) Accommodating the injured employee in appropriate situations by modifying work schedules, equipment, and/or duties to enable the employee to enjoy equal employment opportunities. Institute the early return to work program in compliance with the Texas Department of Insurance, Division of Workers' Compensation's employer guideline and System Regulation.

(4) Explaining any employee benefit programs that may be available to the employee in addition to workers' compensation coverage. Notify the employee when the state health care insurance payment will cease. Provide the employee with information to continue his/her health coverage should he/she choose to do so.

B. Responsibilities to System Office of Risk Management and the TDI, DWC include:

(1) Gathering all pertinent information regarding the job related injury and reporting it to System Office of Risk Management. This will include witness statements if circumstances warrant.

(2) Maintaining a detailed record of the job related injury, even if the employee did not lose time from work as a result of the injury. This record must be maintained for at least five years after the date of injury.

(3) Filing the "Employers' First Report of Injury" (DWC-1) form with the System Office of Risk Management if the employee misses more than one day of work due to the injury, if the injury is an occupational disease, or if the injury resulted in a work related death. The DWC-1 must be mailed or delivered to the System Office of Risk Management not later than the second day after the employee's absence from work for more than one day due to the injury or, in the case of an occupational disease, not later than the second day after receiving notice that the employee has contracted an occupational disease. In the event of critical injury or death, immediate telephone notification should be given to System Office of Risk Management (at 979/458-6330) followed by the DWC-1 form.

(4) Submitting a "Supplemental Report of Injury" form to System Ofice of Risk Management if the employee has missed more than one day from work due to the work related injury. The report must be filed as follows:

Within three days after --

(a) the injured employee returns to work; or

(b) the injured employee, after returning to work, experiences an additional day or days of disability as a result of the initial injury.

Within ten days after --

(a) the end of each pay period in which the injured employee has a change in earnings as a result of the injury; or

(b) the employee resigns or is terminated.

(5) Submitting a "Request for Paid Leave" form with the First Report if the employee loses more than one day. The employee may choose to utilize any accrued sick or vacation leave for the time lost due to the injury, or be placed on leave without pay. Note: By law, the employee has the right to elect not to utilize accrued paid leave for this lost time.

a. If an employee elects to use accrued sick leave before receiving income benefits, the employee must exhaust his/her accrued sick leave.
b. An employee may elect to use all or any number of weeks of accrued annual leave after the employee's accrued sick leave is exhausted.

(6) Submitting the "Employer's Wage Statement" if the injured employee misses more than seven days of work due to the injury.

(7) Posting notice of the TDI, DWC OMBUDSMAN program in English and in Spanish.

(8) Providing the injured employee with a copy of the DWC-1 and his/her rights and responsibilities under the Texas Department of Insurance, Division of Workers' Compensation each time an incident is reported.

(9) Posting employee notice regarding exposure to certain communicable disease.

III. WHAT ARE THE INJURED EMPLOYEE'S RESPONSIBILITIES?

Any employee of The Texas A&M University System who suffers an accidental injury or occupational disease as a direct result of and in the course and scope of employment should immediately notify his/her supervisor. Failure to report the injury within 30 days of the occurrence of the injury (or the manifestation of the occupational disease) may result in the denial of the claim. The employee's notification must include information as to the type of injury sustained, how the injury occurred, and the names of witnesses, if any.

The employee is also responsible for contacting his/her benefits department in order to ascertain whether other benefits (group health, disability, and retirement) are affected by the workers' compensation insurance claim.

The employee will be required to file a "Notice of Injury and Claim for Compensation" form with the TDI, DWC. The employee will receive this form in the mail directly from the Division. The deadline for filing this form is one year after the date of the accident or manifestation of the occupational disease.

The employee must notify the System Office of Risk Management of any change in income regardless of whether the income increased or decreased. If the employee starts working after a period of lost time, or has been made a bona fide offer of employment he/she must notify the System Office of Risk Management, even if employment or offer is not within The Texas A&M University System.

The employee must tell his/her doctor how he/she was injured and if he/she believes it may be work-related.

The employee has the responsibility to tell the TDI, DWC and the System Office of Risk Management how to contact them. If home address, work address, or phone number changes the employee should notify the System Office of Risk Management and TDI, DWC.

IV. WHAT ARE THE EMPLOYEE'S BENEFITS?

Workers' Compensation Insurance payments may be categorized under the general areas of: (A) medical payments; (B) loss income payments; (C) impairment payments, (D) supplemental income payments, (E) Lifetime income benefits and, (F) death/survivor income benefits.

A. Medical Payments

If an employee's injury is found to be compensable under the workers' compensation insurance program, the employee is entitled to health care reasonably required by the nature of the compensable injury. The injured employee is entitled to the employee's initial choice of any doctor that treats workers' compensation injuries. This choice of doctor should be documented on the "Employer's First Report of Injury" form. The employee may not change treating doctors without approval from the TDI, DWC. If the employee changes a treating doctor without approval from the TDI, DWC, the employee may become personally responsible for any medical treatment rendered by the unauthorized physician. Details on how to change one's treating doctor will be provided to the employee by the TDI, DWC.

When purchasing prescription drugs for treatment of the work related injury, the employee should not use his/her group health plan card. Many pharmacies will bill System Risk Management directly upon verification of coverage. Personal items are generally not covered by the workers' compensation insurance program.

Unless the injured employee has received medical treatment from an unauthorized physician, he/she should not be billed directly for health care which is required to treat his/her work related injury. If the employee does receive a bill from a health care provider, the employee should immediately send the bill to System Office of Risk Management for processing. All expenses for medical treatment are subject to the fee guidelines established by the TDI, DWC.

B. Loss Income Payments

Payments for the injured employee are generally expressed in terms of "weeks of compensation." Currently, one week's payment is equal to seventy percent (70%) of the employee's average weekly wage for employees who earn $8.50 per hour or more.

The payments will be equal to seventy-five percent (75%) of the employee's average weekly wage for the first twenty-six weeks of disability if the employee earns less than $8.50 per hour.

The average weekly wage is calculated from the "Employer's Wage Statement" using a formula defined in The Texas Labor Code Section 408.041-047. The weekly payment is subject to a statutory maximum and minimum payment. No payments accrue during the first seven days of absence from work due to the injury. During this "elimination" period, the employee must utilize accrued sick leave, accrued vacation leave, or be placed on "leave without pay" status. If the disability continues for two weeks, the elimination period then becomes payable provided the employee was placed on "leave without pay" status.

If absence extends beyond seven days, the employee has the choice of continuing to receive full wages under accrued sick leave or vacation leave if available, or applying for weekly compensation payments. If weekly compensation payments are paid, the employee must be placed on "leave without pay" until he/she returns to work or receives a full duty release to return to work from his/her treating doctor. It is the employee's responsibility to inform his/her supervisor of this choice and the department or unit must keep System Office of Risk Management advised of current leave status. The employee is also responsible for maintaining his/her other insurance coverage while on leave without pay.

Payment of weekly compensation for a job related injury or occupational disease will not extend beyond 401 weeks except in very limited circumstances when an employee is found to be totally and permanently disabled.

C. Impairment Payments

If an employee's injury results in a whole body permanent impairment greater than zero (0%) the employee will be entitled to three weeks of payments for each percentage of impairment as certified by an authorized licensed doctor.

D. Supplemental Income Payments

If an employee's whole body permanent impairment is 15% or greater the employee may be entitled to monthly payments. An employee's entitlement may extend until the employee returns to work earning at least 80% of his/her pre-injury average weekly wage, or the expiration of 401 weeks from the date of injury. To remain eligible for supplemental payments, the injured employee must attempt in good faith to obtain employment commensurate with his or her ability to work.

E. Death/Survivor Income Benefits

If the injury or occupational disease results in the death of the employee, the current statute provides for a lump sum funeral expense benefit. In addition, the surviving spouse is eligible for a weekly benefit payable until the spouse's death or re-marriage. In the event of re-marriage, a lump sum payment equal in amount to the benefits due for a period of two years will be paid to the surviving spouse. Surviving children may be eligible to share a portion of the weekly death benefits.

Any beneficiary entitled to receive death benefits must first file a "Statement of Beneficiary" form with System Office of Risk Management and TDI, DWC. More detailed instructions regarding claims for death benefits may be obtained by calling System Office of Risk Management at (979)-458-6330 or toll free at (866)249-8574.

V. EMPLOYEE TERMINATION

Since terminating an employee is a managerial decision, System Office of Risk Management cannot and will not make decisions regarding the retention or termination of injured employees who are receiving workers' compensation benefits and are unable to work. However, we do strongly suggest that caution be used in terminating any employee who is disabled and who is (or has been) receiving workers' compensation benefits. Employees must not be discriminated against because they are physically or mentally disabled. The following website (http://www.eeoc.gov/facts/jobapplicant.html) is a website of the applicable provisions of the Rehabilitation Act of 1973 and the Americans With Disabilities Act (Title I, effective July 26, 1992), which prohibit such discrimination.

VI. NOTICE OF COVERAGE TO EMPLOYEES

The general "notice to employees" provision (posters and written notices) found in Art. 8308, Sec. 3.24 of the Texas Workers' Compensation Act do not apply to the members in The Texas A&M University System. However, the following notice provision does apply:

The institution shall give notice to all [employees on the payroll] that, effective at the time stated in such notice, the institution has provided for payment of insurance, (Art. 8309b, Sec. 3, V.T.C.S.).

To comply with this law, the "Notice To Employees of Workers' Compensation Insurance" (TAMUS Form 8) should be signed by all entering employees whose names will appear on the payroll. **This form may not be changed or altered in any manner.**

Additionally, employers are also required to give notice to employees about the Texas Department of Insurance, Division of Workers' Compensation "Ombudsman Program" by displaying posters about the program in English and Spanish. The posters must be prominently displayed in the employer's personnel office, if any, and located about the workplace in such a way that the employee is likely to see the notice on a regular basis. Sample posters are located in this section behind the TAMUS Form 8.

Each System member must post a notice regarding exposure to certain communicable disease. The notice must be in English and Spanish and must be posted in the personnel office and in the workplace where employees are likely to read it. Sample posters are located in the Section "Work Related Communicable Diseases".

THE TEXAS A&M UNIVERSITY SYSTEM
System Risk Management

NOTICE TO EMPLOYEES OF WORKERS' COMPENSATION INSURANCE

Notice is hereby given to all persons employed in the service of and on the payroll of the institutions and agencies under the direction and governance of the Board of Regents of The Texas A&M University System that Workers' Compensation Insurance coverage is provided in accordance with Chapter 502 of the Texas Labor Code.

I hereby acknowledge receipt of this notice that Workers' Compensation Insurance has been provided as above stated.

Date: _____

Employee's Printed Name: _____

Employee's Signature: _____

UIN: _____

System Member: _____

Department: _____

TAMUS Form - 8

This form may not be altered.

Retain in Employee's Personnel File

Rev 06/12

Have you been injured on the job?

The OMBUDSMAN Program

at Texas Department of Insurance, Division of Workers' Compensation

provides free information about how to file a

workers' compensation claim when

a worker is injured or killed on the job.

The OMBUDSMAN explains worker rights and responsibilities

under the Texas Workers' Compensation Act

and responds to complaints about claims.

For information, call the OMBUDSMAN at the Texas Department of Insurance, Division of Workers' Compensation local Field Office or call 1-800-252-7031.

¿ Se ha accidentado en el trabajo?

El Programa OMBUDSMAN

de la Comision Tejana de Compensación a Trabajadores

(Texas Department of Insurance, Division of Workers' Compensation)

le informará, sin costo alguno, sobre la manera de abrir

reclamos de indemnizacion en casos de

trabajadores lesionados o muertos en el trabajo.

El/la OMBUDSMAN le explicará los derechos y

responsabilidades de los trabajadores y

responderá a sus quejas tocante a reclamos.

Para mayor información, comuníquese con el/la OMBUDSMAN

llamando a las of icinas locales de la Comisión Tejana de

Compensación a Trabajadores o marcando el 1-800-252-7031

VII. RECORD-KEEPING AND REQUIRED FORMS

An employer must keep a record of all work-related injuries as reported to the employer or otherwise made known to the employer. The required record of injury must include all of the following information:

(l) The name, address, date of birth, sex, wage, length of service, social security number, and occupation of the injured employee;

(2) The reported cause and nature of the injury, the part of the body affected, and a description of any equipment involved;

(3) The date, time, and location where the injury occurred;

(4) The name of the employee's immediate supervisor;

(5) The names of any witnesses, if known; and

(6) The name of the treating health care provider, if known.

An employer may easily meet the above requirement by completing and retaining a copy of the Employer's First Report of Injury form for every work-related injury. The Texas Department of Insurance, Division of Workers' Compensation rules require that the injury record be kept by the employer until the expiration of at least five years from the last day of the year in which the injury occurred.

In addition to maintaining an injury record, employers are required to file certain forms with the System Office of Risk Management, and, in some instances, the injured employee. The following pages contain detailed information about each of the required forms.

DWC-1 EMPLOYER'S FIRST REPORT OF INJURY

WHAT IS THE FIRST REPORT OF INJURY DESIGNED TO ACCOMPLISH?

The "Employer's First Report of Injury" form (DWC-1) provides written notice to The Texas A&M University System, Office of Risk Management, and TDI, DWC of any potential workers' compensation claim.

WHEN DOES THIS FORM NEED TO BE COMPLETED AND FILED?

An employer must file a DWC-1 form as follows:

(1) For each work related death;
(2) For each occupational disease reported by a worker (even if there is no lost time from work); and
(3) For each injury that results in more than one day's absence from work for the injured worker.

When a DWC-1 form is required, it must be filed with System Office of Risk Management. A copy of the form must also be given to the injured worker at the time the report is taken or sent to the employee's last known mailing address (you must attach a copy of the "Employee's Rights and Responsibilities Form"). The form must be filed no later than two calendar days after the employee's absence for more than one day from work due to injury or death. If the reported injury is an occupational disease, the DWC-1 form must be filed no later than the two calendar days after the employer has knowledge of the occupational disease. "Knowledge" means receipt of written or verbal information regarding diagnosis of an occupational disease, or the diagnosis of an occupational disease through direct examination. If the incident occurs on the day prior to a holiday or weekend, the report must be received by the System Office of Risk Management on the next working day following the holiday or weekend. The form is considered filed when personally delivered, mailed, electronically submitted or sent via facsimile. The employer shall maintain a record of the date the first report of injury (DWC-1) was filed with the System Office of Risk Management.

A monetary penalty may be assessed against the employer (i.e., the System member responsible for the injured employee) for failing to file the DWC-1 form on time or failure to maintain a record of the date reported to System Office of Risk Management. Therefore, it is extremely important to file the DWC-1 within the prescribed time period and maintain a record of your filing date.

An injury is compensable under the workers' compensation program if the injury occurs within the course and scope of employment. "Course and scope of employment" means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer, and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer.

The term includes activities conducted on the premises of the employer or at other locations. The term generally does not include transportation to and from the place of employment. Even if an injury does occur within the course and scope of employment, it will not be compensable if it occurs: (l) from willful self-infliction; (2) while the employee is illegally attempting to injure another person; (3) while the employee is engaged in "horseplay;" (4) while the employee is voluntarily participating in certain employer sponsored off-duty activities; (5) due to an act of God; (6) while the employee is in a state of intoxication; or (7) due to an act of a third person intending to injure the employee because of personal reasons and not directed at the employee because of employment status.

A mental trauma injury is compensable only if it results from a single traumatizing incident (except a legitimate personnel action). Repetitive mental trauma is not compensable.

A heart attack is compensable only if it: (l) occurs at a definite time and place; (2) is caused by a specific event, either physical strain or a "sudden stimulus" but not mental or emotional stress; and (3) the work, not a pre-existing condition or disease, is a substantial contributing factor.

When there is any question as to whether or not an accident or disease qualifies under the workers' compensation program, please call the System Office of Risk Management. In most cases, we will request that you file the DWC-1 and allow us to investigate the claim formally before a decision is made. If you have evidence tending to show that a reported injury is not compensable or if you have any information about a questionable claim, please submit this information to System Office of Risk Management by separate memorandum. <u>It is also helpful to have the claimant write a description of what happened, what was hurt in his/her own words, and sign it.</u>

WHERE TO FILE

Complete the DWC-1 according to the specific directions attached to the form, and file as directed:

(l) Original
The Texas A&M University System
Risk Management
A&M System Bldg. Ste. 1120
200 Technology Way
College Station, Texas 77845-3424
wci@tamu.edu

(2) Copy of DWC-1 with a copy of the Employee's Rights and Responsibilities to Injured Employee's last known address.

(3) Copy
Injured Employee's Representative (if any).

(4) Copy
Employer Record/File. The retained copy of the DWC-1 form may be used as the employer's required injury record discussed previously in this procedure and management standard.

DWC FORM-1
(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 -1 (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-1)

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

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (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.

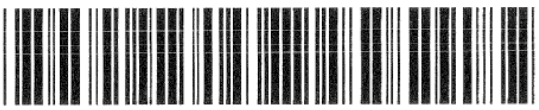
An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

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 Article 8308 -5.04. 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 Article 8308 - 7.03 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:	Article 8308 - 2.13(e), 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		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 _____

EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY

WHAT IS THE SUPPLEMENTAL REPORT DESIGNED TO ACCOMPLISH?

The "Employer's Supplemental Report of Injury" form (DWC-6) is required by the TDI, DWC to account for any period of time lost from work for which the injured worker might be entitled to compensation payments. It also serves as written notice to System Office of Risk Management of an employee's lost time and return to work after a period of disability.

WHEN DOES THIS FORM NEED TO BE COMPLETED AND FILED?

For all injuries that require the filing of a DWC-1 form, the employing department must file a DWC-6 with System Office of Risk Management and the injured employee no later than three days after the occurrence of any one of the following events:

(1) The injured employee begins to lose time from work if lost time did not occur immediately following the injury;
(2) The injured employee returns to work after having lost time from work; or
(3) The injured employee, after returning to work, experiences an additional day or days of disability as a result of the initial injury.

The DWC-6 form must be filed with System Office of Risk Management and the injured employee within ten days of any one of the following events:

(1) The injured employee has a change in earnings as a result of the work related injury; or
(2) The injured employee resigns or terminates employment.

The DWC-6 form should be submitted as often as necessary to report subsequent periods of lost time or returns to work.

The employer shall maintain a record of the date the DWC-6 form is filed with System Office of Risk Management and provide a copy to the employee. If a report has not been received by System Ofice of Risk Management the employer has the burden of proving the report was filed within the required time frame. The employer has the burden of proving that good cause exists if the employer failed to file the report.
Failure to comply with the above requirements without good cause is a Class D administrative violation. Penalties will be imposed by TDI, DWC.

COMPLETING AND FILING THE FORM

Please complete the DWC-6 form carefully. It should be typed or printed legibly in ink. All information must be provided as this form serves as notification to either stop or begin payments. Do not leave a question blank when completing the employer based information.

Most of the questions on the DWC-6 form are self-explanatory. However, some confusion may arise when an employee has returned to work after one period of disability and then begins a second period of lost time for the same injury. If you have questions about completing the form please contact System Office of Risk Management.

WHERE TO FILE.

(I) The Texas A&M University System
Risk Management
A&M System Bldg. Ste. 1120
200 Technology Way
College Station, TX 77845
wci@tamu.edu

(2) The Injured Employee's Last Known Address

(3) Injured Employee's Representative (if any)

(4) Employer's file with date showing when the form was submitted to System Office of Risk Management

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 | 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

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

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

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

EMPLOYER'S WAGE STATEMENT

WHAT IS THE EMPLOYER'S WAGE STATEMENT DESIGNED TO ACCOMPLISH?

The Texas Workers' Compensation Act provides for payment of weekly income payments in certain instances. The rate of compensation to which an employee is entitled is based upon his or her "average weekly wage" as defined in the law. The information in the Employer's Wage Statement (DWC-3) is necessary to properly calculate the employee's average weekly wage.

WHEN DOES THIS FORM NEED TO BE COMPLETED AND FILED?

The DWC-3 form is required whenever the employing department knows or should have known an employee is disabled, or will be disabled at least 8 days cumulatively for a work-related injury. The employing department must file the DWC-3 within 30 days of the eighth day of disability. Failure to comply with this requirement may result in fines being levied directly against the employer (i.e. the System member responsible for the injured employee) by the Texas Department of Insurance, Division of Workers' Compensation.

An amended DWC-3 must be filed with System Office of Risk Management within seven days after any fringe benefit is suspended.

> Example: If the injured employee is using FMLA leave while receiving weekly income payments, the initial DWC-3 must include the state contribution for health insurance. When FMLA leave is exhausted, an amended DWC-3 must be filed within the seven day period, indicating the employer did discontinue payment of health insurance benefits along with the date it was discontinued.

WHERE TO FILE THE DWC-3

(1) The Texas A&M University System
Risk Management and Safety
A&M System Bldg. Ste. 1120
200 Technology Way
College Station, TX 77845
wci@tamu.edu

(2) The injured employee

(3) The injured employee's legal representative (if any)

(4) Employer's file with date showing when the form was submitted to System Office of Risk Management

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT

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 not to exceed $500.00 for an initial offense and not to exceed $10,000.00 for a repeated administrative violation.

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:	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.

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																		

REQUEST FOR PAID LEAVE FORM

What is the RFPL Form Designed to Accomplish?

The "Request For Paid Leave" (RFPL) form allows an employee who has been injured on the job and is unable to work as a result of the injury to elect to remain on the payroll and use some or all of his or her accrued leave in lieu of receiving weekly workers' compensation insurance (WCI) payments. The employer is prohibited from requiring the use of paid leave to cover time lost. Therefore, the RFPL form is used to verify whether the employee has chosen to use paid leave or to receive weekly WCI Benefits.

When is the RFPL Required?

The RFPL form should be completed as soon as the injured employee begins to lose time from work.

What are the employee's options?

When the employee is presented with the RFPL for decision and signature, the department should be sure that all options have been clearly explained to the injured employee.

The employee may initially elect to utilize accrued sick and/or vacation leave to cover all or part of a period of disability, or the employee may elect to preserve his or her leave and be placed on leave without pay from the first day of lost time. This is an exception to the general policy that one must exhaust all leave to which one is entitled before being placed on leave without pay as is the case with FMLA leave. However, if the employee chooses to use accrued sick leave, the employee must exhaust his sick leave during the disability period. Once the sick leave is exhausted the employee may elect to use none, a portion, or all of their accrued vacation.

The injured employee is not entitled to weekly income benefits under the WCI program until the employee has lost seven full days of work due to the injury. (These seven days need not be consecutive.) Benefits accrue on the eighth day of disability and are paid weekly. Only if the employee's total time lost exceeds two weeks will the employee be eligible for retroactive payment for the first seven days (if the employee did not elect to use accrued leave). If the employee has a qualifying disability, FMLA leave (if approved) will run concurrently with the WCI disability.

Workers' compensation weekly benefits are calculated at 70% of the employee's average weekly wage (75% of the employee's weekly wage for employees earning less than $8.50 per hour for the first 26 weeks of disability). The maximum weekly benefit amount changes annually based upon the state average weekly wage as determined by the Texas Employment Commission. Therefore, the higher the employee's salary or wage, the less attractive workers' compensation weekly benefits will be. The employee

might elect to continue to use his or her accrued leave until it is exhausted or until he or she is able to return to work simply to avoid reducing income and to preserve benefits.

If the employee elects to "save" his or her accrued leave, or if the employee has no accrued leave to utilize, he or she will be placed on leave without pay, and workers' compensation benefits will begin following the seven day elimination period (provided that inability to work is medically substantiated). The employee's credit toward TRS and longevity may also be affected depending upon how long the disability lasts and whether or not the employee returns to work. For questions please contact the Human Resources Office.

Completing and filing the form

Once the above factors have been explained to the employee and he or she understands how many hours of accrued leave are available, the RFPL form should be completed and the employee's signature obtained. When the form has been completed and signed, the original should be forwarded to the System Office of Risk Management. In the event the employee is unable to personally appear and sign the form, document on the RFPL that the employee was contacted by phone, the date, and who spoke with the employee. The contacting employee should sign the RFPL and forward it to System Risk Management and Safety.

Return To: Risk Management and Safety
The Texas A&M University System
A&M System Bldg. Ste. 1120
200 Technology Way
College Station, Texas 77840-7896
(979)458-6330
wci@tamu.edu

THE TEXAS A&M UNIVERSITY SYSTEM
System Risk Management

WORKERS' COMPENSATION INSURANCE
REQUEST FOR PAID LEAVE

Please forward promptly with the DWC-1 after an injury resulting in lost time.

Name of Employee _____ **Date of Injury** _____

Social Security # _____ **Claim Number** _____

If you sustain a disabling on-the-job injury covered by Workers' Compensation Insurance, you may remain on the payroll until your accrued paid leave is exhausted. If you have not been released to return to work by your treating doctor after accrued paid leave is exhausted, you will be placed on Leave Without Pay. Workers' Compensation Weekly Wage Replacement Benefits, as prescribed by Statute, will be initiated.

An employee may elect to use accrued sick leave before receiving income benefits. If an employee elects to use sick leave, the employee is not entitled to income benefits until he/she has exhausted their accrued sick leave. An employee may elect to use all or any number of weeks of accrued vacation after the employee's accrued sick leave is exhausted. If an employee elects to use vacation, he/she is not entitled to income benefits until the elected number of weeks of vacation has been exhausted.

TOTAL LEAVE AVAILABLE _____ ***SICK LEAVE*** _____ ***VACATION***

_____ I wish to use all of my accrued sick leave to remain on the payroll from _____ through _____. I choose not to use any of my accrued vacation. Workers' compensation weekly wage replacement benefits will begin after accrued sick leave is exhausted, provided I have not been released to return to work by a doctor.

_____ I wish to use all of my accrued sick leave to remain on the payroll from _____ through _____. After my accrued sick leave is exhausted, I wish to use a portion or all of my vacation to remain on the payroll from _____ through _____. After such time workers' compensation weekly wage replacement benefits will begin, provided I have not been released to return to work by a doctor.

_____ I do not wish to use any portion of my accrued paid leave to remain on the payroll. Therefore, I will be placed on leave without pay. Workers' compensation weekly wage replacement benefits will begin on the 8th day of disability resultant from my work related injury, provided I have not been released to return to work by a doctor.

While using accrued sick leave and/or vacation the employer is paying $_____ per week in gross wages to the injured employee.

Injured employee's signature or signature of person submitting form on the employee's behalf:

Signature _____ **Date** _____

Return to: *Office of Risk Management* 301 Tarrow Street, 5th Floor College Station TX 77840-7896
Phone 979-458-6330 ◆ Fax 979-458-6247 Campus Mail Stop 1262

Revised 04/12

Seguro de Compensación al Trabajador
The Texas A&M University System

SOLICITUD DE LICENCIA PAGADA

Favor de enviar rápidamente dentro de los siete primeros días después de la lesión que resulte en pérdida de tiempo laboral.

Nombre del Empleado_____Fecha de la lesión_____

Seguro Social_____Numero de Reclamación_____
(sí se conoce)

Si usted sufrió una lesión en su trabajo cubierta por el seguro de compensación al trabajador, usted puede permanecer en la nómina de pago hasta que su tiempo compensatorio por enfermedad se haya agotado. Si usted no tiene permiso del doctor para regresar a trabajar y su acumulación de tiempo de licencia pagada se agotó, el sistema lo pondrá en licencia sin pago. El seguro de compensación al trabajador empezará a pagar su salario semanal, de acuerdo a lo prescrito en la ley.

El empleado puede usar sus días de licencia por enfermedad acumulados antes de recibir beneficios compensatorios. Si el empleado elige usar sus días de licencia por enfermedad, el empleado no tiene derecho a recibir los beneficios de compensación al trabajador por esos mismos días de acuerdo a lo prescrito en la ley.

El empleado puede usar parcial o totalmente su tiempo de vacaciones acumulado después de que se hayan agotado todos los días de licencia por enfermedad. Si el empleado elige usar sus días de vacaciones, el empleado no tiene derecho a beneficios compensatorios hasta que el término estipulado de vacaciones se haya agotado.

Total de licencia disponible _____Días _____Horas

Quiero usar todos mis días acumulados de licencia de enfermedad para permanecer en la nómina a partir de _____ hasta_____. Después de esa fecha los beneficios de pago semanal de compensación al trabajador comenzarán a correr, si no he sido dado de alta por el doctor para regresar a trabajar.

Después de que mis días de licencia por enfermedad acumulados se hayan agotado, yo quiero usar el total de mis vacaciones para permanecer en la nómina de _____ hasta_____. Después de esa fecha los beneficios de pago semanal de compensación al trabajador comenzarán a correr, si no he sido dado de alta por el doctor para regresar a trabajar.

Después de que mis días de licencia por enfermedad acumulados se hayan agotado, yo quiero usar una porción de mis vacaciones para permanecer en la nómina de _____ hasta_____. Después de esa fecha los beneficios de pago semanal de compensación al trabajador comenzarán a correr, si no he sido dado de alta por el doctor para regresar a trabajar.

Yo no quiero usar ninguna porción de mis días de licencia acumulados para permanecer en la nómina. Por lo tanto, el sistema me pondrá en licencia sin pago. Los beneficios de compensación al trabajador reemplazarán el pago de nómina semanal y comenzarán el octavo día después de la lesión ocurrida en el trabajo si no he sido dado de alta por el doctor para regresar a trabajar.

_____ _____
La firma de la empleado herida, o firma de la persona obtener información. Fecha

Devolver: The Texas A&M University System
Risk Management
A&M System Building, Suite 1120
200 Technology Way
College Station, Texas 77845
(979) 458-6300
wci@tamu.edu

VIII. BUILDING AND CONSTRUCTION CONTRACTS

When a "building or construction" contract is entered into by an institution or agency within The Texas A&M University System, the institution or agency should require the contractor with whom the contract is made to certify in writing that the contractor provides workers' compensation insurance coverage for all employees of the contractor employed on the building or construction project. Likewise, any subcontractor employed on the building or construction project should provide such a written statement relating to the coverage of any employees of the subcontractor working on the project to the project manager.

"Building or construction" as used in this context includes erecting or preparing to erect any structure, as well as repairing, remodeling, extending, or demolishing a structure. It also includes improving real property or appurtenances thereto.

The TDI, DWC has adopted five interim forms (DWC-81, DWC-82, DWC-83, DWC-84, and DWC-85) which address agreements made between hiring contractors, independent contractors, and subcontractors. **These forms are of no consequence to any of the members within The Texas A&M University System and may properly be disregarded.** If you are asked by a contractor or subcontractor to sign one of the above mentioned forms, you may explain to him/her that the forms do not apply to The Texas A&M University System or to any of the members within the System. Alternatively, you may direct the contractor or subcontractor to the System Office of Risk Management so that one of our staff members may discuss this matter with him/her.

IX. Work-related Communicable Diseases

Pursuant to Rule 110.108 of The Texas Workers' Compensation Act employers are required to post notice concerning exposure to certain communicable diseases. The notice must be posted in the personnel office, and in the workplace where employees are likely to read the notice on a regular basis. This notice will inform employees of exposure reporting and disease testing requirements which may affect qualifying for workers' compensation benefits.

A list of reportable communicable diseases is as follows:

Acquired immune deficiency	Amebiasis	Anthrax
Botulism-adult & infant	Brucellosis	Campylobacteriosis
Chancroid	Chickenpox	Chlamydia
Trachomatis infection	Cholera	Dengue
Diphtheria	Encephalitis	Escherichia coli 0157:h7
Gonorrhea	Hansen's disease (leprosy)	Hemophilus influenzae infections invasive
Hantavirus infection	Hemolytic uremic syndrome(HUS)	Hepatitus, 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 fever
Yellow fever	This list may change from time to time	

This list applies only to employees employed as a law enforcement officer, a fire fighter, an emergency medical service employee, a paramedic, or a correctional officer. **All state employees who claim a possible work related exposure to HIV are subject to the communicable disease rulings regardless of their employment classification.** Exposure must have occurred in course and scope of employment while the employee is furthering the affairs of the employer. The employee must provide the employer with a sworn affidavit of the date and circumstances of the exposure and document that, not later than the 10th day after the date of the exposure, the employee had a test result that indicated an absence of the reportable disease.

The cost of the testing within the first 10 days will be paid for by the Texas A&M University System Office of Risk Management. Negative test results within the first 10 days could be considered compensable if all other requirements of compensability are present. Positive test results within the first 10 days would be considered non-compensable. The presence of a positive test within the first 10 days of exposure would be a factual finding of exposure not in the course and scope of employment.

Claims for compensability of communicable diseases must be reported to the employer within ten days of the exposure. The employer must provide the following documents to System Risk Management:

1. First Report of Injury/Illness (DWC1)
2. Documentation of Testing (name and address of provider)
3. Sworn Affidavit of the date and circumstances of the exposure

Failure to provide any of these documents may result in a finding of non-compensability.

X. RETURN TO WORK GUIDELINES

Early Return to Work Program
Standard Administrative Procedure

GENERAL

1.1 The purpose of this Standard Administrative Procedure (SAP) is to implement and administer an Early Return to Work Program, while ensuring fairness and consistency for the employees of The Texas A&M University System (the System) and its components. Herein the term "employee" refers to any employee of the System and/or its components and "employer" will refer to the supervising unit of the System component. This SAP is intended as a guide and does not create a contract, implied or expressed, with any employee. The System reserves the right to modify this SAP in whole or in part at any time at the discretion of the System Office of Risk Management & Safety.

1.2 The objective of the program is to return employees to safe and productive employment as soon as medically possible following an injury/illness in either their pre-injury/illness job without restrictions or in a temporary work assignment, if available, as described in section 4.

1.3 The program does not obligate the employer to create work or to return an employee who has had an injury/illness to work if there is no appropriate work available.

1.4 The program does obligate the employer to try to provide meaningful work consistent with the employee's knowledge, skills, and physical capabilities within the limitations specified by the employee's physician, if reasonably possible.

1.5 This SAP is intended as a minimum standard. Each System component is authorized to implement its own procedures as long as the intent of this SAP is met in the procedures set forth.

BENEFITS

2.1 Early return to work following an injury/illness is beneficial to both the employer and the affected employees.

2.1.1 *Benefit to Employees* - Employees remain active and productive; concerns about continued employment may be resolved; full or partial wages are earned bringing income closer to pre-injury/illness wages; employees experience less disruption to their lives; loss of physical fitness and muscle tone due to inactivity may be prevented; employees maintain pre-injury/illness benefits; and maintain contact with and support from co-workers and friends.

2.1.2 *Benefit to the Employer* - Productivity is maintained; the employer retains the production of skilled and experienced employees; expenses are reduced for recruiting, hiring, training, or salary of replacement employees; overtime may be

lessened to make up for lost production; work delays and business interruptions are eliminated or reduced when experienced employees return to work; Workers' Compensation costs (if applicable) are reduced when injured employees return to work; communications and relationships between employees and their department are enhanced based on the commitment by all parties; and the employer's interest and concern for employees is reinforced.

ELIGIBILITY REQUIREMENTS

To be eligible to participate in this program the individual must be a current employee of the System, have been an employee of the System at the time the injury/illness occurred, and be temporarily unable to return to pre-injury/illness duties as a result of an injury/illness.

TEMPORARY WORK ASSIGNMENTS (TWA)

4.1 **Temporary Work Assignments -** can be the bridge to help employees return to their pre-injury/illness job without restrictions. TWA may be made when employees temporarily cannot perform the duties of their job due to injury/illness and have been released to work with restrictions by their physician. TWA will be monitored by the supervisor/departmental representative and must be consistent with the employee's knowledge, skills, and physical capabilities within the limitations specified by the employee's physician. The following are recommended types of TWA:

4.1.1 *Modified Regular Duty* - This may include temporary modifications to the employee's position such as schedule changes, reduced hours, reduced capacities, or sharing parts of job responsibilities with co-workers.

4.1.2 *Alternate Work Assignments* - The supervisor/departmental representative may consider jobs or tasks that need to be done and may accept input from the employee and the employee's co-workers to identify everyday or new tasks that could be done by the employee as a temporary assignment.

4.1.3 *Alternate Work Location* - The employee may request the opportunity to temporarily work at an alternate work location. The supervisor/departmental representative will consider whether or not the employee meets the eligibility criteria and will determine if the alternate work location assignment will be beneficial to the department.

PREPARATION FOR IMPLEMENTING THE PROGRAM

5.1 The supervisor/departmental representative will review and maintain current position descriptions to ensure work and physical requirements are accurate.

5.2 The component safety office and/or the System Office of Risk Management & Safety are available as a resource for workplace or safety procedure review.

5.3 Departments should inform employees and supervisors about the program and communicate the benefits.

PROCEDURE FOR IMPLEMENTING THE PROGRAM FOR A SPECIFIC EMPLOYEE

6.1 **Americans with Disabilities Act (ADA)** - In situations where the employee has special needs that merit consideration under the ADA, the employee and/or supervisor/departmental representative should contact their employer's human resources department (HR) for guidance. Participation in the Early Return to Work Program shall not be construed as recognition by the employer that the employee has a disability as defined by the ADA.

6.2 **Family Medical Leave Act (FMLA) -** When an employee experiences an injury/illness, the supervisor/departmental representative, in addition to following the procedures specified in this SAP, must follow the procedures specified in *System Regulation 31.03.05 Family and Medical Leave* and may wish to review the FMLA 101 Tutorial.

6.2.1 An FMLA eligible employee that has been released by a physician to return to work with restrictions may elect to use FMLA leave rather than participate in the program under a TWA, if 12-workweeks of FMLA have not been exhausted during the fiscal year. If the injury/illness has been accepted as compensable under Workers' Compensation, the election to use FMLA leave rather than participate in the program under a TWA may result in a reduction or discontinuance of workers' compensation temporary wage replacement benefits.

6.2.2 If an FMLA eligible employee voluntarily elects to participate in the program under a TWA, that is for reduced work hours due to the physician's restrictions, the hours the employee is not physically at work will count towards FMLA, if the employee has not exhausted 12-workweeks of FMLA during the fiscal year.

6.3 **Work-related Injury** - If the injury/illness is work-related, the supervisor/departmental representative, in addition to following the procedures specified in this SAP, should follow the Workers' Compensation procedures specified in *System Regulation 24.01.02*.

6.4 **Work-related or Non-work-related Injury/Illness**

6.4.1 If the department receives medical documentation indicating physical restrictions, the supervisor/departmental representative will attempt to identify a TWA as explained in section 4.

6.4.2 If it is unclear from the medical documentation whether or not the employee can safely perform the duties of the pre-injury/illness position description, the supervisor/departmental representative will request that the employee sign the *Information Release on Ability to Perform Job Duties Form*. The supervisor/departmental representative will give the employee the original of the completed *Physician's Early Return to Work Program Information Sheet* with an attached Texas A&M *System Early Return to Work Program – Work Status Report*, the original of the *Information Release on Ability to Perform Job Duties Form*, and a

copy of the employee's position description to provide to the physician for clarification.

6.4.3 If the department receives updated medical documentation, the supervisor/departmental representative will attempt to identify a TWA as explained in section 4.

Information Release on Ability to Perform Job Duties Form

Date: _____

Employee's Name: _____

Date of Birth: _____

I authorize my physician, _____, to release medical information to _____ (a representative of employer) addressing my ability to perform the duties of the job description as described on the attached document.

I understand that my physician providing this information may help facilitate my return to medically-appropriate, productive work under my Employer's Early Return to Work Program. I understand that I may obtain a copy of the Standard Administrative Procedure (SAP) _____ (component name) Early Return to Work Program from my supervisor or by downloading the SAP at _____ online.

_____

Print employee's name

_____ _____

Employee's Signature **Date**

Distribution: Original - Physician Copy - Department and Employee

HR Department 02/2005

Physician's Early Return to Work Program Information Sheet

Date: _____

Physician's name and address:

_____

_____

_____

Subject: Employee's name _____

Dear Dr. _____:

_____ (component name) has implemented an Early Return to Work Program designed to return an injured or ill employee to medically-appropriate work as soon as possible. You may obtain a copy of the (component name) Standard Administrative Procedure _____ (SAP number) describing the Early Return to Work Program at _____(web site address) online or by contacting me _____(HR Representative) at _____ (phone number).

Enclosed is a detailed job description for the pre-injury/illness job of the employee named above, which may be temporarily modified, if possible, to meet the employee's current medical restrictions. If the employee is unable to return to his or her pre-injury/illness job, we will attempt to find an appropriate temporary alternate work assignment. We will ensure that any assignment meets all medical requirements as they appear on form DWC-73 Work Status Report (if due to a work-related injury/illness) or on the attached Early Return to Work Program – Work Status Report (if due to a non-work-related injury/illness). We will consider rearranging work schedules around medical appointments, if necessary.

For your convenience, you may provide the completed Work Status Report to the employee or fax the document to _____(fax number). If you need additional information about a possible temporary work assignment or about our Early Return to Work Program, please call me at _____ (phone number).

Thank you for your participation in our efforts to return our employees to a safe and productive workplace.

Sincerely,

_____ _____

Signature of Departmental Representative Department

Attached: Signed *Information Release on Ability to Perform Job Duties Form*
Early Return to Work Program – Work Status Report
Job description

Distribution: Original - Physician Copy - Department and Employee

HR Department 02/2005

Draft **Early Return to Work Program - Work Status Report**

Note: This form is to be used only for injuries/illnesses that are NOT work-related. **(Referenced in section 6.4.2)**

PART I: GENERAL INFORMATION	4. Doctor's Name
1. Employee's Name	5. Clinic/Facility Name
2. Date of Injury or illness	6. Clinic/Facility/Doctor Phone & Fax
3. Medical facts of condition	7. Clinic/Facility/Doctor Address (street address)
	8. City State Zip

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

9. The injured employee's medical condition resulting from the injury or illness:

☐ (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* (REQUIRED IF BOX 9 (b) IS CHECKED)

10. POSTURE RESTRICTIONS (if any):

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

11. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist

☐ L Arm ☐ R Arm ☐ Neck

☐ L Leg ☐ R Leg ☐ Back

☐ L Foot/Ankle ☐ R Foot/Ankle

☐ Other: _____

13. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	_____
Climbing stairs/ladders	☐	☐	☐	☐	☐	_____
Grasping/Squeezing	☐	☐	☐	☐	☐	_____
Wrist flexion/extension	☐	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	☐	_____
Overhead Reaching	☐	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	_____

14. LIFT/CARRY RESTRICTIONS (if any):

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

for more than ____ hours per day

☐ May not perform any lifting/carrying

☐ Other: _____

15. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____

☐ Sit/Stretch breaks of _____ per _____

☐ Must wear splint/cast at work

☐ Must use crutches at all times

☐ No driving/operating heavy equipment

☐ Can only drive automatic transmission

☐ No work / ☐ _____ hours/day work:

☐ in extreme hot/cold environments

☐ at heights or on scaffolding

☐ Must keep _____:

☐ Elevated ☐ Clean & Dry

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No Running

12. OTHER RESTRICTIONS (if any):

16. 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 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

17. 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
Discharge Time		

BONA FIDE OFFER OF EMPLOYMENT (BOE)

7.1 If a TWA is identified, the supervisor/departmental representative will prepare a BOE for the employee to review and sign, indicating a decision. The employee may not perform work until the BOE is signed.

7.2 After the employee accepts or declines the BOE, or if the employee fails to respond to the BOE, the supervisor/departmental representative will provide the employee with a copy of the BOE with the employee's signature or a statement indicating the employee failed to respond, and a copy of the medical documentation that the BOE is based upon.

7.3 If the injury/illness is work-related, the supervisor/departmental representative will fax to the Workers' Compensation representative for their respective component the BOE with the employee's signature or a statement indicating the employee failed to respond, and the medical documentation that the BOE is based upon.

7.4 While working under a BOE, the employee is expected to follow all employer policies, regulations and rules, maintain satisfactory performance of the job duties outlined in the BOE, and comply with all of the terms and conditions of the BOE. Failure to do so may result in termination of the BOE and other disciplinary action up to and including termination. Contact the employer’s human resources department for guidance.

(referenced in section 7)

Bona Fide Offer of Employment

Certified Mail # _____
DATE: _____
MEMORANDUM
TO: _____
FROM: _____
SUBJECT: Bona Fide Offer of Employment (BOE)

After reviewing the information provided by your physician, we are pleased to offer you the following temporary work assignment as part of the _____ (component name) Early Return to Work Program. You may obtain a copy of _____ (component name) Standard Administrative Procedure _____(SAP number) Early Return to Work Program from your supervisor or at _____ (website address) online. If any training is required to do this assignment, it will be provided.

Job title: _____
Location: _____
Description of physical requirements of this position: _____
_____
Job tasks: _____
_____
Duration of assignment: From: ___/___/___to___/___/___ (maximum of 45 calendar days per injury/illness)
Work Hours: From: _____ a.m. / p.m. to: _____ a.m. / p.m. **Days of Week:** M Tu W Tr F Sa Su
Pay: _____ per □ Hour □ Week □ Month
Department: _____**Supervisor:** _____

This temporary assignment will be reviewed on ___/___/___, unless medical documentation is provided sooner indicating the restrictions due to your medical condition have changed or you are released to full duty. You must submit updated medical documentation given to you by your medical provider by your next scheduled workday.

Family Medical Leave Act (FMLA) Information: If you are eligible for FMLA and have not used 12-workweeks of FMLA during this fiscal year, you may choose to decline this offer and utilize FMLA job protection. If you are eligible for FMLA and choose to accept this BOE and it is for reduced work-hours due to the restrictions placed on you by your physician, the time you are not at work will count towards your available FMLA balance.

Workers' Compensation Insurance (WCI) Information: If your injury is covered by WCI, refusal of this job offer may impact your Temporary Income Benefit payments.

This job offer will remain open for two (2) workdays from your receipt of this memorandum. If we do not hear from you within two (2) workdays, it will be determined that you have refused this offer. We look forward to your return to work. If you have any questions, please contact me at_____.

I accept / refuse (circle one) the above offer of employment.

Signature of Employee: _____**Date:** _____

Or

The employee has failed to respond. **Signed:** _____ **Date:** _____

Attached: Copy of medical documentation that BOE is based upon.
Distribution: Original - Department Copy – Employee

(If work-related, fax a copy of BOE and medical documentation to _____ (component HR dept. fax number) and Risk Management & Safety @ 979-458-6247.)

NOTICE OF INABILITY TO IDENTIFY A TEMPORARY WORK ASSIGNMENT

8.1 If the supervisor/departmental representative is unable to identify a TWA, the employee will be provided a copy of the completed *Notice of Inability to Identify a Temporary Work Assignment* and a copy of the medical documentation that the *Notice* is based upon.

8.2 If the injury/illness is work-related, the supervisor/departmental representative will fax to the Workers' Compensation representative for the respective component the *Notice of Inability to Identify a Temporary Work Assignment* and the medical documentation that the *Notice* is based upon.

8.3 If the department receives updated medical documentation, the supervisor/departmental representative will attempt to identify a TWA as explained in section 4.

(Print on Departmental Letterhead)

(referenced in section 8)

Notice of Inability to Identify a Temporary Work Assignment

Certified Mail # _____

DATE: _____

MEMORANDUM

TO: _____ / _____
Name Title

FROM: _____ / _____
Name Title

SUBJECT: Notice of Inability to Identify a Temporary Work Assignment

We have attempted to identify a temporary work assignment as described by _____ (component name) Standard Administrative Procedure (SAP) _____(SAP Number)Early Return to Work Program. After reviewing the information provided by your physician, however, we have been unable to identify a temporary work assignment with tasks in line with the restrictions as described by your physician on the attached DWC-73 Work Status Report or _____ (component name) Early Return to Work Program – Work Status Report and consistent with your knowledge, skills, and physical abilities. You may obtain a copy of the Early Return to Work Program SAP _____ (SAP number) from your supervisor or download it at _____ (web site address) online.

If your medical condition changes, you should provide the updated medical documentation to _____ (departmental representative) within two working days.

Family Medical Leave Act (FMLA) Information: If you are eligible for FMLA and have not exhausted 12-workweeks of FMLA during this fiscal year, the time you are not at work due to this medical condition will count towards your FMLA.

Workers' Compensation Insurance (WCI) Information: If your injury/illness has been accepted as compensable under WCI, you may be eligible for Temporary Income Benefit payments.

We look forward to your return to work. If you have any questions, please do not hesitate to contact me at _____ (phone number).

Attached: Copy of medical documentation that this *Notice of Inability to Identify a Temporary Work Assignment* is based upon.

Distribution: Original - Department Copy – Employee
(Note: if work-related, fax a copy of this *Notice* and the medical documentation to _____(Component HR fax number) and to Risk Management & Safety @ 979-458-6247.)

CONTINUING PARTICIPATION IN THE PROGRAM

9.1 The TWA described on the BOE is subject to regular re-evaluation.

9.1.1 If the treating physician changes the physical work restrictions, the employee will provide the updated medical information to the supervisor/departmental representative by the next scheduled workday.

9.1.2 Upon receiving updated medical information, the supervisor/departmental representative will re-evaluate the ability to provide a TWA based on the restrictions outlined by the physician.

9.2 The opportunity to participate in the program is a temporary measure to facilitate early return to work and will not exceed 45 calendar days in duration per injury/illness, commencing upon the date the department offered the first BOE for the injury/illness (see Section 7.1). If the employee is unable to return to unrestricted pre-injury/illness job duties by the end of the 45 days, the employee's opportunity to participate in the program will end. To determine the employee's employment status at that time, the department should consult with human resources.

9.3 In no case is the employer obligated to extend participation in the program past the expected duration of the position the employee occupied prior to the injury/illness.

TERMINATION DUE TO BUSINESS NECESSITY

Termination due to business necessity is an option if an employee is unable to return to unrestricted pre-injury/illness job duties, or the department is unable to identify a TWA, or an employee declines a BOE, and the employee has exhausted or is ineligible for FMLA. Supervisors and departmental administrators requiring assistance in determining whether to terminate an employee due to business necessity so that the work of the department may be effectively handled, should contact the employer's human resources department, where a *Termination Due to Business Necessity Checklist* is available. Involuntary termination of nonfaculty employees must be reviewed by the employer's human resources department.

****

Contact for Interpretation — System Office of Risk Management Safety

Legal Sufficiency

_____

General Counsel

Approval

_____

Director, Office of Risk Management & Safety

What is the Early Return to Work Program?

- It is a team approach to managing employee injuries/illnesses within the Component by returning the employee to work as soon as the employee's physician determines it is medically possible, if meaningful work can be identified.
- It is a unique, flexible program that attempts to meet the diverse needs of both the employee and the Component.

Why do the Components offer this?

- To lessen the impact of the human cost to employees who have sustained an injury or are recovering from an illness:
  - Loss of income
  - Loss of self-esteem
  - Loss of control over one's life
  - Loss of personal and professional relationships
- To lessen the impact of the cost to the Component:
  - Cost of replacing the injured/ill employee
  - Cost of hiring temporary employees
  - Cost of training new staff
  - Reduced productivity among remaining employees
  - Poor morale resulting from feelings of not being considered a valued employee

What are the primary goals of the program?

- Retain valued, experienced employees
- Offer safe, timely return of injured/ill employees back to the workforce
- Reduce the costs for employees and the Component for injuries/illnesses

What are the key components of the program?

- Initiate a change in how supervisors/departmental representatives perceive employees who are temporarily unable to return to full duty and realize they can still be productive individuals.
- Provide procedures and tools for supervisors/departmental representatives to utilize when responding to employees who have experienced an injury/illness.
- Assist supervisors/departmental representatives with:
  - Communicating appropriately with treating physicians and providing them the necessary information to assist in returning employees back to work
  - Maintaining communication with injured/ill employees to preserve good working relationships
  - Developing transitional employment duties, if available, within the physical restrictions specified by the physician, while utilizing employees' knowledge, skills, and abilities.

How long may an employee participate in the program?

The opportunity to participate in the program is a temporary measure to facilitate early return to work and will not exceed 45 calendar days in duration per injury/illness, commencing upon the date the department offered the first Bona Fide Offer of Employment for the injury/illness. If the employee has not returned without restrictions to the pre-injury/illness position by the end of the 45-calendar day Temporary Work Assignment (TWA), the employee's opportunity to further participate in the program will end.

What is a Bona Fide Offer of Employment (BOE)?
If the supervisor/departmental representative identifies temporary work consistent with the employee's knowledge, skills, and physical capabilities within the limitations specified by the employee's physician, the supervisor/departmental representative will prepare a document called a BOE providing specific information relative to the temporary work assignment ("light duty"). The employee may not perform work until the BOE is signed.

What about the employee who may be disabled as defined by the Americans with Disabilities Act (ADA)?
In situations where an employee has special needs that merit consideration under the ADA, the employee and/or supervisor/departmental representative should contact the Human Resources Department Employee Relations Office at _____(phone number) or _____(e-mail) for guidance.

May the employee who has Family Medical Leave Act (FMLA) job protection that has been released to work with restrictions by a physician elect to not participate in the program?
Yes, the employee who is eligible for FMLA and has not previously exhausted 12-workweeks of FMLA during the fiscal year may elect to use FMLA leave rather than participate in the program under a BOE.

Does the decision to decline a BOE negatively impact an employee who was injured on the job?
If the injury/illness has been accepted as compensable under Workers' Compensation, the decision to decline a BOE may result in reduction or discontinuance of workers' compensation temporary wage replacement benefits.

If an employee voluntarily accepts a BOE for reduced work-hours due to the restrictions placed on the employee by the physician, does the time the employee is not at work count towards the employee's FMLA?
Yes, the time not physically at work will count towards the employee's FMLA if the employee is eligible for FMLA and has not already exhausted 12-workweeks of FMLA during the fiscal year.

What happens if an employee is unable to return to unrestricted pre-injury/illness job duties?
If an employee is unable to return to unrestricted pre-injury/illness job duties and the employee has exhausted or is ineligible for FMLA, termination due to business necessity is an option. Involuntary termination of nonfaculty employees must be review by the Employee Relations Office.

Where may further information be obtained regarding the program?
For further information, contact the Employee Relations Office at _____ (e-mail address) or _____ (phone number).

04/2006

XI DEFINITIONS

1. **"Administrative violation"** means a violation of the Texas Workers' Compensation Act or a rule adopted under the Act that is subject to penalties and sanctions as provided in the Act. Fines can be 25,000.00 per violation. Each day is a separate violation.

2. **"Benefit"** means a payment benefit received based on a compensable injury. The term includes a medical payment, income payment, impairment payment, and a death or burial benefit.

3. **"Division"** means the Texas Department of Insurance, Division of Workers' Compensation.

4. **"Compensable injury"** means an injury that arises out of and in the course and scope of employment for which compensation is payable under the Workers' Compensation Act.

5. **"Course and scope of employment"** means an activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer.

6. **"Employer"** means a person who makes a contract of hire, employs one or more employees, and has workers' compensation insurance coverage. The term includes a governmental entity that self-insures, either individually or collectively.

7. **"Health Care"** includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation.

8. **"Injury"** means damage or harm to the physical structure of the body and those diseases or infections naturally resulting from the damage or harm. The term also includes occupational diseases.

9. **"Insurance Carrier"** means an insurance company, a certified self-insurer for workers' compensation insurance, or a governmental entity that self-insures, either individually or collectively.

10. **"Maximum Medical Improvement"** means the earlier of:
    A. the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated; or
    B. The expiration of 104 weeks from the date on which temporary income benefits begin to accrue.

11. **"Occupational Disease"** means a disease arising out of and in the course of employment that causes damage or harm to the physical structure of the body, including a repetitive trauma injury. The term includes a disease or infection that naturally results from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is an incident to a compensable injury or occupational disease.

12. **"Repetitive Trauma Injury"** means damage or harm to the physical structure of the body occurring as the result of repetitious, physically traumatic activities that occur over time and arise out of and in the course and scope of employment.

13. **"Wages"** include every form of remuneration payable for a given period to an employee for personal services. The term includes the market value of board, lodging, laundry, fuel, and other advantages that can be estimated in money which the employee receives from the employer as part of the employee's remuneration.

APPENDIX A

Texas Department of Insurance, Division of Workers' Compensation
Field Office Locations

TDI, DWC FIELD OFFICE'S	ADDRESS
Abilene	**1290 S. Willis, Suite 102** **Abilene, TX 79605-4064** **325/695-4992**
Amarillo	**7112 IH-40 West, Bldg D** **Amarillo, TX 79106-2503** **806/351-1222**
Austin	**4616 West Howard Lane, Suite 130** **Austin, TX 78728** **512/933-9828**
Beaumont	**Concord Square Office Park** **6430 Concord Rd** **Beaumont, TX 77708-4315** **409/899-5589**
Bryan/College Station	**4001 East 29th Street, Suite 185** **Bryan, TX 77802-4211** **979/268-6766**
Corpus Christi	**5155 Flynn Parkway, Suite 218** **Corpus Christi, TX 78411** **361/883-2551**
Dallas	**1515 W. Mockingbird, Suite 100** **Dallas, TX 75235-5069** **214/350-3750**
Denton	**Dallas Dr. Tech Center** **625 Dallas Dr., Suite 475** **Denton, TX 76205-7289** **940/380-1400**
El Paso	**El Paso State Office Building** **401 Franklin Avenue, Suite 330** **El Paso, TX 79901** **915/834-7000**
Fort Worth	**Walton Building** **6900 Anderson Blvd., Suite 200** **Fort Worth, TX 76120-3011** **817/446-4488**
Houston East	**Elias Ramirez Building** **5425 Polk Street, Suite 130** **Houston, TX 77023-1423** **713/924-2200**
Houston West	**507 North Sam Houston Parkway East** **Suite 600** **Houston, TX 77060** **281/260-3035**
Laredo	**5420 Springfield Avenue** **Laredo, TX 78041** **956/718-2040**
Lubbock	**22 Briercroft Office Park, Suite A** **Lubbock, TX 79412-3089** **806/744-4569**
Lufkin	**310 Harmony Hill Dr., Suite 100** **Lufkin, TX 75901** **936/639-6425**

Midland/Odessa	**Executive Office Park** **4500 West Illinois Avenue, Suite 315** **Midland, TX 79703-5486** **432/699-1281**
Missouri City	**2440 Texas Parkway, Suite 240** **Missouri City, TX 77489** **281/403-7061**
San Angelo	**State of Texas Services Center** **622 S. Oakes, Suite M** **San Angelo, TX 76903-7013** **325/657-0404**
San Antonio	**9514 Console Drive, Suite 200** **San Antonio, TX 78229-2043** **210/593-0070**
Tyler	**3800 Paluxy Drive, Suite 570** **Tyler, TX 75703-1665** **903/534-6250**
Victoria	**American General Building** **3001 North Cameron Street** **Victoria, TX 77901-3931**
Waco	**Raleigh Building** **801 Austin Ave., Suite 840** **Waco, TX 76701-1937** **254/755-7011**
Weslaco	**1108 Pike Blvd** **Weslaco, TX 78596** **956/447-4416**
Wichita Falls (appointments only-injured employees call 800/252-7031 for assistance)	**Chelsea Plaza** **909 8th Street, Suite 112** **Wichita Falls, TX 76301** **940/767-2691**

APPENDIX

WORKERS' COMPENSATION QUESTIONS & ANSWERS

NOTICE TO EMPLOYEES OF WORKERS' COMPENSATION INSURANCE (TAMUS 8):

Q: Are new employees still required to sign a copy of the Notice to Employees of Workers' Compensation Insurance (TAMUS Form 8)?

A: Yes. Each newly hired employee is required to sign TAMUS Form 8. The signed form should be retained in the employee's personnel file.

FIRST REPORT OF INJURY/ILLNESS FORM (DWC-1):

Q: Are partial days missed from work counted in determining whether or not an employee has missed more than one day of work due to a compensable injury?

A: Partial days missed from work should be counted if an employee is absent because he or she is "disabled." For instance, if an employee's regular daily shift is eight hours long but the employee is only able to work four hours per day pursuant to doctor's orders, the employee will have lost more than one day of work due to his or her injury after the third day of working only four hours per day.

* "Disability" is defined as the inability to obtain and retain employment as a result of a compensable injury.

Q: If an employee's supervisor knows an employee has sustained a work-related injury but the employee never formally reports the injury, must the DWC-1 form be filed if the employee misses more than one day of work due to the injury?

A: Yes. An employee who is injured on the job is not required to "formally" report the injury if his or her supervisor (or anyone with supervisory responsibilities) has actual knowledge that the injury was sustained in the course and scope of employment.

Q: Who should complete the DWC-1 form?

A: The DWC-1 form should be completed and signed by someone designated to act on behalf of the employer. The injured employee should not complete or sign this form.

SUPPLEMENTAL REPORT OF INJURY FORM (DWC-6):

Q: If an employee is missing intermittent periods of time from work, how often must a Supplemental Report of Injury form be filed?

A: A new Supplemental Report of Injury form should be filed each time the employee returns to work after having lost time from work and/or each time the employee, after returning to work, experiences an additional day or days of disability as a result of the injury.

Q: Is time taken off for appointments with the doctor or physical therapist considered lost time? Should these dates be listed on the Supplemental Report of Injury form?

A: The answer to both of these questions is "no." Lost time is that period of time during which the injured employee is physically unable to work due to a compensable injury.

Q: When an employee returns to work part time, restricted duty do I need to complete a supplemental?

A: Yes.

WAGE STATEMENT (DWC-3):

Q: On the Wage Statement, what should be done when the employee did not work for 13 consecutive weeks prior to the date of injury and there is no same or similar employee who worked for 13 consecutive weeks prior to the date of injury?

A: If no same or similar employee worked for 13 full weeks prior to the date of injury, fill out the form using the injured employee's actual wages for the time worked prior to the date of injury. Please include an explanatory statement on the Wage Statement form.

FOR EXAMPLE:

*The wages reported are the employee's actual wages for the 13 week period prior to the injury. There is no same or similar employee who worked the entire 13 weeks prior to the date of injury because our facilities were closed for two full weeks during that 13 week period.

Q: Should the dollar amount of sick leave and/or annual leave pay which was paid to the injured employee during the 13 week period covered by the Wage Statement be listed under the heading "Fringe Benefits" or under the heading "Salary/Wages?"

A: The dollar amount paid for sick leave, annual leave, overtime, and/or holiday pay should be included in the Gross Pay column under the heading "Wage Information." Do not include the dollar amount under the "Fringe Benefit" heading.

Q: If uniforms are provided to an employee; but the uniforms must be returned upon termination of employment, are they considered a "Fringe Benefit?"

A: Although there has been no definitive ruling on this matter, it is our policy not to consider uniforms a fringe benefit for purposes of calculating an employee's average weekly wage if the uniforms remain the property of the employer and must be returned upon termination of employment.

Q: Should the total amount paid for health insurance during the 13 weeks covered by the wage statement be listed under "Fringe Benefits" on the wage statement, or should only the monthly contribution be listed?

A: List only the amount of the state contribution.

REQUEST FOR PAID LEAVE (RFPL):

Q: When an employee loses intermittent periods of lost time, does the employee have to complete a new RFPL form each time.

A: Yes. A new RFPL form should be completed each time an employee misses work due to an on-the-job injury.

Q: How should the RFPL form be filled out if the employee is unable to come in and sign the form?

A: It is very important to get the employee's signature on the RFPL form. If the employee is unable to sign the RPL form, we recommend that you call the employee and document the employee's decision on the form. After the employee's decision is recorded on the form, please sign the form as follows:

APPROVED BY PHONE (DATE)

_____

Signed: (Your Signature)

BENEFITS:

Q: If an employee is receiving weekly workers' compensation payments for loss of wages, how does it effect the state contribution toward benefits?

A: An employee who is off work and receiving weekly workers' compensation payments is in a "Leave Without Pay" status. Questions regarding continuation of insurance coverage should be directed to the Benefits Office of the employing system member.

Q: May an injured employee who is receiving workers' compensation benefits intermittently use sick and/or annual leave in order to retain entitlement to the state contribution toward insurance premiums?

A: No

Q: Is an employee entitled to mileage reimbursement when he or she must travel to receive medical care?

A: An employee may be entitled to reimbursement for travel if it becomes reasonably necessary to travel more than 30 miles (one way) in order to obtain appropriate and necessary medical care.

Q: Can an employee who is receiving workers' compensation benefits also be eligible for Long Term Disability, Unemployment Compensation, and/or Social Security Disability benefits?

A: Yes. Receipt of workers' compensation indemnity payments does not make a person ineligible for the benefits listed above. Please contact the Benefit Programs office for specific information regarding eligibility for Long Term Disability.

Q: Are workers' compensation benefits taxable?

A: Workers' compensation payments are currently not subject to federal income taxation. If an employee has specific questions about this matter, we recommend that the employee be directed to the Internal Revenue Service or to his or her legal advisor.

Q: When do medical benefits become available to an employee who sustains an on-the-job injury?

A: Medical benefits are available immediately to a worker who is injured in the course and scope of employment. [NOTE: An employee should not use his or her health insurance card to obtain medical treatment for a compensable on-the-job injury.]

Q: What if an employee attempts to obtain workers' compensation benefits to which he or she is not entitled?

A: An employee who attempts to obtain workers' compensation benefits to which he or she is not entitled should be warned that there are now serious penalties for making false or misleading statements, misrepresenting or concealing material facts, and/or fabricating, altering or concealing documents in order to obtain benefits. Monetary penalties may be assessed against an employee by the Texas Department of Insurance, Division of Workers' Compensation for any of these deceptive actions. Additionally, it is a criminal offense (up to a second degree felony, depending on the dollar amount involved) to knowingly commit any of the above listed acts in an attempt to wrongfully obtain workers' compensation benefits.

Q: Should health care providers send medical bills and/or reports to the employer?

A: No. Health care providers are required by law to submit properly completed medical bills to System Risk Management within 15 days of the date of initial treatment. Subsequent billing must be at least monthly for services and treatments rendered. All medical bills for compensable injuries are to be submitted to System Risk Management Safety only. Under no circumstances are providers to seek payment directly from injured employees for treatment of compensable injuries. If health care providers are sending bills and/or medical reports to locations other than System Risk Management, please inform them that the bills and reports are to be sent to the address below:

The Texas A&M University System
Office of Risk Management & Safety
A&M System Bldg. Ste 1120
200 Technology Way
College Station, TX 77845
wci@tamu.edu

Since System Risk Management must meet strict guidelines with regard to payment of medical bills, it is essential that health care providers be informed of the appropriate location to send bills and reports. If bills and/or reports are received late because they are routed to one of the System members instead of being sent to System Risk Management and Safety, interest charges and other penalties may accrue on the amounts owed to the providers.

INJURED EMPLOYEES

If an employee's injury claim is denied under the WCI program, he or she receives a Plain Language Notice (PLN-1) explaining the reason for denial. The employee also receives information on how to request a hearing before the TDI, DWC if the employee wishes to appeal the denial.

If an employee's claim is accepted and the employee has missed more than one day of work as a result of the injury, he or she receives a standard acceptance letter. The acceptance letter identifies the employee's claim adjuster and provides information about the TDI, DWC Ombudsman program. The information on the following pages is sent to the injured employee with the acceptance letter.

WORKERS' COMPENSATION INFORMATION FOR INJURED EMPLOYEES

THE TEXAS A&M UNIVERSITY SYSTEM
SYSTEM RISK MANAGEMENT & SAFETY
WORKERS' COMPENSATION INSURANCE

WORKERS COMPENSATION INFORMATION FOR INJURED EMPLOYEES

We have received information that indicates that you may have sustained an injury while performing duties on behalf of your employer. At this time, we have no reason to dispute your claim. Please read all the information enclosed so that you will fully understand your rights and responsibilities under The Texas Workers' Compensation Act. If you have questions that are not answered, please call this office at (979) 458-6330 or (866) 249-8574. Your adjuster will be glad to answer any questions you may have.

WHAT IS WORKERS' COMPENSATION INSURANCE

Workers' compensation is a form of insurance specifically designed to provide reasonable and necessary medical benefits and in some circumstances, indemnity benefits to employees on the payroll of The Texas A&M University System who suffer injuries or occupational disease in the course and scope of their employment. Workers' Compensation is not health insurance, nor does it provide compensation for damage to or loss of personal property. You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefits if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured while voluntarily participating in an off-duty activity, you were injured by an act of God, or your injury occurred during horseplay.

The Texas A&M University System is self-insured for workers' compensation coverage. Therefore, no private insurance company is involved in the process. The entire workers' compensation program is administered by the System Office of Risk Management. You should not use your health insurance coverage for work related injuries.

OBTAINING MEDICAL SERVICES

You have the right to receive the medical care reasonable and necessary to treat your work-related injury or illness for the rest of your life. You have the right to the initial choice of doctor. You should immediately choose a treating doctor to coordinate your care as it relates to your work-related injury if you have not already done so. You have the responsibility to tell your doctor how you were injured and if you believe it may be work-related. If possible tell the doctor *before* the doctor treats you. Tell your treating doctor that any bills for your work-related injury should be sent directly to the System Office of Risk Management at the address on the following page.

The Texas A&M University System
Risk Management
A&M System Building, Suite 1120
200 Technology Way
College Station, Texas 77845-3424
wci@tamu.edu

Bills for services not specifically related to your on-the-job injury should be sent to your regular health insurer or should be paid by you.

CHANGING TREATING DOCTORS

You do not need to get approval to go to a different doctor for emergency treatment. If it becomes necessary to change treating doctors you must notify The Texas Department of Insurance, Division of Workers' Compensation in writing of your desire to change treating doctor prior to changing, and the reason you wish to change doctors. The Division must approve any change of doctor after your initial choice of treating doctor. To request a change of treating doctor contact the field office handling your claim, or call 1-800-252-7031.

OBTAINING A SECOND OPINION

You are expected to comply with your treating doctor's treatment plan. However, if you are not seeing any improvement after a reasonable amount of time, we will be happy to assist you in getting a second opinion from another physician. You may also obtain a second opinion for any surgical procedure prior to the surgery.

OBTAINING ASSISTANCE

You have the right to receive assistance from appropriate, qualified Division staff, and in the event of a dispute resolution proceeding, from a Division Ombudsman free of charge. To request assistance, contact the field office handling your claim, or call 1-800-252-7031. Your rights and responsibilities will be explained under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Division ombudsman in informal dispute resolutions and in administrative proceedings if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you. You have the right to hire an attorney. You also have the right to contact your adjuster or the WCI Manager at 979-458-6330 or 1-866-249-8574 to assist you, or attempt to resolve disputes.

CONFIDENTIALITY

You have the right to confidentiality. Only people who need to know-such as your doctor, your employer or your employers' insurance carrier (The System Office of Risk Management)-may see information in the Division's files. A prospective employer may get limited information from the Division about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for him or her to do so. The System Office of Risk Management will not release any information in your claim file, to anyone other than yourself without your express written permission to do so, except for people who need to know as outlined above. If you wish your spouse, son, daughter, friend, or relative to receive information about your claim you must provide written approval for release of information.

COMMUNICATING WITH YOUR EMPLOYER

The System Office of Risk Management, in administering the workers' compensation insurance program, does not act as your employer. You have the responsibility to tell your employer about your injury or illness. You must tell your employer within 30 days of the date you were injured, or within 30 days of the date you first knew your illness might be work-related. If you do not tell your employer within 30 days, you could lose your right to receive benefits.

You are expected to continue communicating with your immediate supervisor about your work related injury throughout any period of disability, just as you would if you had sustained a non work-related injury. If you must lose time due to your work-related injury, your supervisor should receive a written note from your treating doctor to indicate that you are unable to work. If you choose to miss work on your own without your treating doctor's order, your disability, for purposes of computing lost time under the Workers' Compensation Act will be disputed.

If you have lost time due to your work-related injury, you are expected to return to work as soon as you are physically able. If your doctor releases you to return to work with restrictions, work with your supervisor to comply with any restrictions placed on you by your doctor.

DISPUTES REGARDING YOUR CLAIM

If a problem or dispute arises in your claim at any time, please write a brief note to the adjuster assigned to your claim. Briefly explain in the note what your complaint or problem concerns. If the dispute cannot be resolved by working with the adjuster, the adjuster will put you in contact with the Texas Department of Insurance, Division of Workers' Compensation.

FRAUDULENTLY OBTAINING BENEFITS

If you know that the injury for which you are seeking benefits is not truly work-related or if you have no disability as a result of your injury, you are expected to provide this information to the System Office of Risk Management.

It is an administrative violation to knowingly or intentionally do one of the following in an attempt to obtain workers' compensation benefits for you or for another person:

- Make a false or misleading statement;
- Misrepresent or conceal a material fact;
- Fabricate, alter, conceal, or destroy a document; or
- conspire to commit one of the above

In addition to being an administrative violation, doing any of the above acts in an attempt to obtain benefits may also result in criminal charges. (Criminal punishments for wrongful receipt of workers' compensation benefits range from Class A misdemeanor to second-degree felony.)

This office keeps detailed records of every workers' compensation injury claim filed by employees on the payroll of The Texas A&M University System.

PHYSICAL EXAMINATION AT OUR REQUEST

The System Office of Risk Management may, at some point while your claim is pending, exercise our right to have you evaluated by a physician of our choice for your work-related injury. Such an evaluation will be done to determine if you are disabled due to your work-related injury and the appropriateness of the health care received. If you are asked to see a physician chosen by us, you will be given notice of the appointment at least ten days in advance.

INCOME FROM OTHER SOURCES

If you are losing time from work due to your work-related injury but are receiving income from any other job during the course of your disability, you must notify this office immediately. You have a responsibility to tell the Division and this office any time your income changes

If you are getting benefits and you have changed employers since your injury, tell the Division and insurance carrier paying your benefits if your income changes. Tell the Division and insurance carrier regardless of whether your income went up or down.

If you have stopped working since your injury, tell the Division and the insurance carrier if you start working again or if you have a job offer.

FILING YOUR NOTICE OF INJURY

If you have lost time from work due to your injury or filed an occupational disease, you should receive an "Employee's Notice of Injury" form (DWC-41) from the Texas Department of Insurance, Division of Workers' Compensation. You have a responsibility to fill out this claim form and send it to the Division. You must send a completed DWC-41 claim form to the Division within one year of the date you were injured, or within one year of the date you first knew your illness might be work-related. Send the completed claim form to the Division even if you are already getting benefits. If you do not send the form within one year, you could lose your right to get benefits. For a copy of the form call the field office handling your claim, or call 1-800-252-7031.

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

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 (TDI). TDI 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). Also, more information is available on the Internet at: **www.oiec.state.tx.us <http://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 of Workers' Compensation is available on the Internet at: **<http://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-duty recreational, social, or athletic activity.

2. You have the right to receive medical care to treat your workplace injury or illness. There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.

3. Choosing 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.
- If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
- 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.

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) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.

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 who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

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.

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 TDI 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 TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at **<http://www.tdi.state.tx.us/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 provider 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 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 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

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

7. 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.**

Aviso sobre los derechos y responsabilidades para los empleados lesionados en el Sistema de Compensación para Trabajadores de Texas

En Texas, como empleado lesionado, usted tiene derecho a recibir ayuda gratis por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel - OIEC, según su nombre y siglas en inglés) La ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también ofrecen otros servicios del sistema de compensación para trabajadores del Departamento de Seguros de Texas (Texas Department of Insurance – TDI, según su nombre y siglas en inglés). TDI es la agencia estatal que administra el sistema por medio de la División de Compensación para Trabajadores.

Para comunicarse con la Oficina de Asesoría Pública para el Empleado Lesionado llame gratis al 1-866-EZE-OIEC (1-866-393-6432). Para más información, visite el sitio electrónico www.oiec.state.tx.us.

Para comunicarse con la División de Compensación para Trabajadores llame gratis al 1-800-252-7031. Para más información sobre la División de Compensación para Trabajadores, visite el sitio electrónico http://www.tdi.state.tx.us/wc/indexwc.html.

Sus derechos en el Sistema de Compensación para Trabajadores de Texas:

1. **Usted puede tener derecho a recibir beneficios.**

   Usted puede tener derecho a recibir beneficios sin importar quien tuvo la culpa de su lesión, con ciertas excepciones, tales como:
   - Si se encontraba en estado de ebriedad en el momento que ocurrió la lesión.
   - Si se lesionó usted mismo a propósito o cuando estaba tratando de lesionar a otro.
   - Si su lesión fue causada por otra persona por razones personales.
   - Si resultó lesionado por un acto de Dios.
   - Si su lesión ocurrió por estar jugueteando, o
   - Si su lesión ocurrió cuando usted voluntariamente participaba en una actividad de recreación, social o atlética fuera de su empleo.

2. **Usted tiene derecho a recibir atención médica para tratar la lesión o enfermedad relacionada con su trabajo. No hay un marco de tiempo límite para recibir la atención médica, siempre y cuando sea médicamente necesaria y en conexión a la lesión relacionada con su trabajo.**

3. **Para escoger a un médico tratante:**
   - Si usted pertenece a una Red de Servicios Médicos de Compensación para Trabajadores red - (Workers' Compensation Health Care Network, según su nombre en inglés) tiene que escoger a su médico de la lista de médicos tratantes en la red.
   - Si no pertenece a una red, usted puede escoger a cualquier médico que esté dispuesto a tratar su lesión de compensación para trabajadores.
   - Si usted es empleado de una subdivisión política (por ejemplo: una ciudad, condado, distrito escolar) tiene que hacer lo indicado por los reglamentos para escoger al médico que lo va a tratar.

Es importante que usted siga todos los reglamentos del sistema de compensación para trabajadores. Si no sigue estos reglamentos, usted podría ser responsable por el pago de las cuentas médicas.

4. **Usted tiene derecho a contratar a un abogado en cualquier momento para que lo ayude con su reclamo.**

5. **Usted tiene derecho a recibir información y ayuda gratis de la Oficina de Asesoría Pública para el Empleado Lesionado.**

   El personal de OIEC está a su disposición para contestar sus preguntas y explicarle sus derechos y responsabilidades. Llame gratis al 1-866-EZE-OIEC (1-866-393-6432) o visite la oficina local de la División de Compensación para Trabajadores/Oficina de Asesoría Pública para el Empleado Lesionado.

6. **Usted tiene derecho a recibir ayuda por parte de un ombudsman si no cuenta con un abogado, en caso que se haya programado un procedimiento de resolución de disputas.**

   Un ombudsman es un empleado de la Oficina de Asesoría Pública para el Empleado Lesionado. Los ombudsman están entrenados en las funciones de compensación para trabajadores y proveen ayuda gratis a los empleados lesionados que no cuentan con la representación de un abogado. Por lo menos, en cada oficina local se encuentra un ombudsman para ayudarlo con la conferencia para revisión de beneficios (benefit review conference – BRC, según su nombre y siglas en inglés), la audiencia para disputar beneficios (contested case hearing – CCH, según su nombre y siglas en inglés) y la apelación. Sin embargo, un ombusman no puede firmar documentos en nombre suyo, hacer decisiones por usted o darle asesoramiento legal.

7. **Usted tiene derecho a que la información sobre su reclamo se mantenga confidencial.**

   En la mayoría de los casos, el contenido del expediente de su reclamo no puede ser obtenido por otros. Algunos participantes del caso tienen derecho a saber lo que contiene el expediente de su reclamo, por ejemplo: su empleador o la compañía de seguros de su empleador. También, puede ser que un empleador que está considerando contratarlo pueda obtener información limitada sobre su reclamo de la División de Compensación para Trabajadores.

Sus responsabilidades en el Sistema de Compensación para Trabajadores de Texas

1. **Usted tiene la responsabilidad de avisarle a su empleador si se ha lesionado en el curso y amplitud de su empleo.**

   Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o a partir de la fecha en que supo que la lesión o enfermedad estaba relacionada con su trabajo.

2. **Usted tiene la responsabilidad de saber si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores (red).**

   Si no sabe si usted pertenece a una red, pregúntele al empleador para quien estaba trabajando

en el momento que sufrió la lesión. Si pertenece a una red, usted tiene la responsabilidad de seguir los reglamentos de dicha red. Su empleador debe darle una copia de los reglamentos de TDI para las redes. Lea los reglamentos cuidadosamente. Si hay algo que no entiende pregúntele a su empleador o llame a la Oficina de Asesoría Pública para el Empleado Lesionado. Si desea presentar una queja contra la red, llame a la Línea de Ayuda al Consumidor de TDI, al 1-800-252-3439 o presente su queja electrónicamente en http://www.tdi.state.tx.us/consumer/complfrm.html#wc

3. **Si usted estaba trabajando para una subdivisión política (por ejemplo: una ciudad, condado, distrito escolar) en el momento que sufrió la lesión, usted tiene la responsabilidad de informarse sobre como recibir tratamiento médico. Es requerido que su empleador le proporcione la información que necesita para que determine cual proveedor de servicios médicos puede darle el tratamiento para la lesión relacionada con su trabajo.**

4. **Usted tiene la responsabilidad de decirle a su médico como sufrió la lesión y si la lesión está relacionada con su trabajo.**

5. **Usted tiene la responsabilidad de llenar y enviar el formulario de reclamo (DWC-41) a la División de Compensación para Trabajadores. Usted cuenta con un año para enviar este formulario a partir de la fecha en que usted se lesionó o a partir de la fecha en supo que su enfermedad estaba relacionada con su trabajo.**

Llene y envíe el formulario DWC-41 aún si usted ya está recibiendo beneficios. Usted podría perder su derecho para recibir beneficios si no envía el formulario a la División de Compensación para Trabajadores. Para pedir una copia del formulario DWC-41 llame al 1-800-252-7031 o al 1-866-393-6432.

6. **Usted tiene la responsabilidad de proporcionar a la División de Compensación para Trabajadores y a la compañía de seguros su domicilio actual, número telefónico y los datos de su empleador.**

7. **Usted tiene la responsabilidad de avisarle a la División de Compensación para Trabajadores y a la compañía de seguros cada vez que tenga un cambio en el estado de su empleo o salario. Algunos ejemplos:**
   - si deja de trabajar debido a su lesión,
   - comienza a trabajar, o
   - le ofrecen un trabajo.