Arlington
INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

To Be Completed by the Injured Employee

This form is to be completed by the injured employee, in their own words. If assistance is provided by a foreign language interpreter, please notate the name and phone number of the interpreter at the bottom of the document.

1. Name_____ Home Phone_____
2. Social Security Number_____ Birth Date _____
3. Department in which you work_____
4. Supervisor's Name_____
5. Date and time of accident_____
6. Have you missed any days from work in relationship to this injury? Yes / No

   List the days _____ _____
7. Location of incident (campus, room, hallway, etc.)_____

   _____
8. Body parts injured? (be specific and list all injured area)_____

   _____
9. Time you began work on day of injury_____
10. Explain how the accident occurred_____

    _____

    _____

10. Were you performing your normal duties? Yes No (circle one)

11. Will you seek medical attention at this time? Yes No (circle one)

If yes, please make sure the doctor you select is in the Political Subdivision Workers' Compensation Alliance. You can locate a doctor http://www.pswca.org/ or by calling TASB, at 1-800-482-7276. Do not pay any money out of your pocket or file a claim on your personal medical insurance. You may be responsible for charges if you go to a physician who is not a member of the Alliance.

12. Any witnesses? Give first and last names

    _____

Injured employee's signature _____

Date signed_____

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Office of Risk Management
To Be Completed by Immediate Supervisor

1. Name of injured employee_____
2. Job title of injured employee_____
3. Date and time of injury _____
4. Location of incident _____
5. Brief description of incident, as reported by injured employee

   _____

   _____

6. Body parts injured as result of incident? (be specific and list all injured areas)

   _____

   _____

7. Nature of injury (contusion, laceration, sprain, etc.)

   _____

   _____

8. The employee seeks medical attention at this time. Yes No (Circle One)

_____ _____
Print name of immediate supervisor Phone number for immediate supervisor

_____ _____
Print name of person completing report Phone number for person completing report

_____ _____
Date incident was reported Date report completed

Please report any questions, concerns or comments related to this claim to the AISD Office of Risk Management, Tina Baze, 682-867-7649.

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Employee Medical Release Authorization

I,_____, Social Security number _____, am reporting a work related injury that occurred on _____, at_____AM or PM.

I have been advised by the Arlington ISD Office of Risk Management that I have the right to visit the doctor of my choice, so long as the doctor is a participating provider in the Political Subdivision Workers' Compensation Alliance Direct Contracting program. I understand that I may locate a participating doctor at www.pswca.org or by calling the Texas Association of School Boards Risk Management Fund at 1-800-482-7276.

I understand that if I do not seek medical treatment at this time, it does not prevent me from doing so at a later date.

The medical provider is hereby authorized to provide the Arlington Independent School District, the Texas Association of School Boards Risk Management Fund, or any of their respective legal representatives, any and all information relevant to my workers' compensation claim and related treatment. This authorization includes permission to copy or view all hospital notes, records and information, including but not limited to laboratory tests and x-rays, histories, examinations, tests, treatment, consultations, and opinions and any and all other information relevant to this claim. Medical information relevant to this claim includes past history of complaints or treatment of any condition related or similar to that presented in the claim or other conditions related to the same body part.

To address privacy concerns, HIPAA Rule 45CFR 512(1) specifically authorizes provider disclosure of protected health information, without an individual's consent, to the extent necessary to comply with workers' compensation laws.

Injured employee's signature _____

Date signed _____

Arlington Independent School District
Office of Risk Management
1203 W. Pioneer Parkway, Arlington, Texas 76013
Office 682-867-7649 Fax 682-867-4685

Employee's Medical Authorization for Work Related Injury or Illness

This is to certify that the below named person is an employee of the Arlington Independent School District and has reported a work-related injury or illness and is entitled to reasonable and necessary treatment of the condition reported. The employee is entitled to select the hospital, doctor and pharmacy of their choice from the participating provider's list of the Political Subdivision Workers' Compensation Alliance. Alliance providers can be located at www.pswca.org or by calling TASB at 1-800-482-7276.

Employee Name_____SS # _____

Date of Injury_____Time of Injury _____

Campus/Department location_____

Description of Injury _____

_____

_____

Supervisor's Name (print) _____

Supervisor's Signature _____

Date_____

For Medical Provider: Please submit copy of DWC Form 73 to the Arlington ISD Office of Risk Management upon completion of initial treatment.

Send charges for services to:

TASB Risk Management Fund
PO Box 400
Austin, TX 78767-0400
Office 1-800-482-7276

Fax copies of DWC 73 to:

Arlington ISD
Office of Risk Management
Attention: Tina Baze
Office 682-867-7649
Fax 682-867-4685

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I may have to pay the bill if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ _____
Signature Date

_____
Printed Name

I live at: _____
Street Address
_____, _____ City
State Zip Code

Name of Employer: Arlington Independent School District

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: _____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

RECONOCIMENTO DEL EMPLEADO PARA EL PROGRAMA DE CONTRATAR DIRECTAMENTE CON MEDICOS

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tartar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opcion, puedo escojer solamente de la lista de doctores aprovados por la Alliance. Una tercera opcion, tendre que recibir aprobación de mi ajustador antes de cambiar.

Signature (Firma):_____ Date (Fecha):_____

Printed Name (Nombre en imprenta): _____

Address (Direccion de domicilio incluindo cuidad, estado y zip):

_____

Employer (Nombre de empleo): Arlington Independent School District

Name of Direct Contracting Program (Nombre del programa de contratar doctores directament): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: www.pswca.org o llame a su ajustador al numero: 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:_____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

Arlington INDEPENDENT SCHOOL DISTRICT
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Family Medical Leave (FMLA) Concurrent with Workers' Compensation

Name:_____ID: _____

Campus:_____Assignment: _____

Current Address: _____

Completed by Benefits Department:

Estimated Start Date of Leave:_____ Estimated Return to Work Date:_____

Reason for Leave (Explain): _____

Note: An employee requesting leave for the employee's serious health condition due to a compensable work-related injury, must submit a verifying medical certification from the Workers' Compensation physician. **(Texas Workers' Compensation Work Status Report (DWC – 73) is acceptable as verification of a serious health condition.)**

In addition, FMLA eligible leave will run concurrently with workers' compensation time away from work.

I authorize a representative of Arlington ISD to contact my health-care provider to verify the authenticity of the medical certification for my requested Family Medical Leave.

I understand that a failure to return to work at the end of my leave period may be treated as absent without leave, and may result in further disciplinary action up to and including termination of employment, unless additional leave, pursuant to Board Policies DEC (Legal) and DEC (Local) has been agreed upon and approved in writing.

Signature:_____Date: _____

I prefer communication be submitted to me via ☐U.S. Mail or ☐district e-mail.

Received by:

Supervisor/Principal:_____ Date: _____

Benefits Department:_____Date: _____

Updated: October 2017

Workers Compensation Notice of FMLA

Employee Name:_____ Position:_____

An employee who has been employed with AISD for at least 12 months and will be out of work 3 days or more, must fill out the FMLA request form in addition to workers compensation forms. Eligible FMLA leave will run concurrently with workers compensation related time away from work.

If we do not receive your signed portion of the FMLA request, you will be contingently designated to be on FMLA pending completion of your application and medical certification from your physician. If your leave does not certify under the FMLA guidelines, or if you fail to complete the application process for FMLA, you will not be eligible for its benefits including job protection.

A certified FMLA leave will protect your position with AISD during your time off of work for up to 12 weeks. (The 12-week entitlement includes all qualifying FMLA leave over the previous 12 months.) After exhaustion of the 12-week FMLA entitlement period, eligible employees will be placed on AISD disability leave for up to an additional 96 calendar days. During disability leave, your current position is no longer guaranteed. If you are released to return to work prior to the expiration of disability leave you may be placed in a similar position with AISD if one is available at the time of your release.

If FMLA and disability leave time has been exhausted and you have not been released to return to work prior to your leave end date, your position with AISD may be terminated. Please see FMLA definitions, eligibility and requirements portion of the FMLA request packet for more information.

The FMLA packet can be found online by going to http://www.aisd.net/district/departments/human-resources/compensation-benefits-and-culture/leaves/, from the AISD homepage click on **Departments,** then **Compensation, Benefits, and Culture,** then **Leaves.** You can also pick up the FMLA packet from the benefits office or have one mailed or emailed to you.

If you have not filled out FMLA paperwork or have any questions, please email hrbeneftis@aisd.net or visit the Benefits Department located in the Central Administration Building at 1203 W. Pioneer Parkway, Arlington, Texas 76013.

Please be aware that if you currently have insurance benefits through AISD, you will be required to make up any missed premiums accrued during your time out. If premiums are not kept current, you will need to make arrangements with the benefits department to pay outstanding premiums. If you do not return to work and your benefits premiums have not been paid, your insurance benefits will be cancelled due to non-payment.

By signing this document, I acknowledge that I have read and understand the above information regarding the Family Medical Leave Act and my job status during this leave.

Employee Signature:_____ DATE:_____