Workmen’s Compensation
A Guide for Administrators
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Overview

Workers’ compensation is a state-regulated insurance program that provides covered employees with income and medical benefits should they sustain a work-related injury or illness. It is regulated by the Texas Department of Insurance; Division of Workers’ Compensation. All South San Antonio ISD employees who are injured within the course and scope of their employment are covered under the District’s Self-Funded Workers’ Compensation coverage.

Guidelines

Relation to Paid Leave

The Board has adopted the offset option by law (CRE Legal), whereby an employee absent because of a job-related illness or injury may choose to receive worker’s compensation wage benefits only, or use available paid leave in proportional amounts to supplement workers’ compensation wage benefits, up to the regular pre-injury weekly wage.

The employee shall indicate if he or she chooses to use available paid leave in this circumstance, and if so, may choose to discontinue use at any time. An employee absent because of a job related illness shall be placed on family and medical leave, if applicable. (DEC Local). The employee must sign the worker’s compensation offset form to make this choice.

Claims

An employee absent from duty one day or more or needing medical attention due to an injury or illness from work-related activities shall present to his/her principal/administrator a certificate of injury or illness by a licensed doctor of medicine, dentistry, or podiatry. Within 24 hours after receiving the certificate of illness or injury from the employee, the principal or administrator shall send the certificate to the Office of Human Resources. All employees are required to promptly report all injuries to their principal/administrator even if medical treatment is not necessary.

Injured employees must report any incident immediately to the supervisor. The employee should not leave the job before the supervisor has been notified, unless the injury requires immediate medical treatment. If the supervisor is not available, the employee should notify the supervisor’s assigned representative. If an employee is absent from duty on worker’s compensation for one day or more or needs medical attention, the employee shall notify his or her principal or supervisor and the Office of Human Resources. The reason for the absence and the anticipated date of return to duty shall be verified by a doctor’s statement. Upon
notification of the injury or illness of an employee, the principal or supervisor will submit the required forms to the Office of Human Resources.

**Verification of Benefits**

Compensation for lost time as a result of a work-related illness or injury is mandated by the Workers’ Compensation Act. Lost time compensation shall be verified by a licensed medical physician, dentist, or podiatrist.

An injured employee may utilize his or her personal leave when a work-related injury prevents his or her returning to the job. However, the employee will not receive compensation greater than 100 percent of his or her normal salary. An injured employee shall furnish the Office of Human Resources a status report, setting forth the condition of the employee and the date of his or her expected return to duty.

An injured employee may receive temporary income benefits (TIBS) if the injury or illness causes the worker to lose some or all income for more than seven (7) days.

**Return to Duty After an Injury**

At the end of any workers’ compensation absence from duty of one to five days, the employee shall notify the Office of Human Resources of the intent to be restored to duty. Medical proof of physical fitness is required. The Office of Human Resources shall notify the employee’s principal or department head of the employee’s intent to be restored to duty. If the employee is absent more than five consecutive days under workers’ compensation, the employee must:

- Report to the Office of Human Resources to receive approval to return to work; and
- Report for work on the date specified by the employee’s doctor.
- If the doctor finds and advises the employee that the employee is physically able to return to work on a specified date, the employee shall return to duty on the date specified.

The Office of Human Resources may require that a licensed doctor of medicine, dentistry or podiatry examine the employee desiring to return to duty, with the cost paid through the workers’ compensation fund. The Office of Human Resources may, at any time, require the employee to submit a doctor’s statement of the employee’s physical fitness to perform the required duties. After an evaluation of medical information, the Office of Human Resources may recommend a change in the assigned duties of the employee.

If the employee fails to report to work on the date specified by the employee’s doctor, timely submit to examination by the doctor specified by the District, or return to work on the date specified by the examining doctor designated by the Office of Human Resources, shall constitute the resignation of the employee from the District for at-will employees and shall be considered a good cause for recommendation of termination or non-renewal of contract personnel. All professional employees under contract must abide by Board policy governing employment.
Return To Work After 30 days: In general, employees certified by a medical doctor to return to work after a job-related injury or illness in excess of thirty (30) working days shall be entitled to restoration to duty, contingent upon a vacancy for which the person is qualified. It is the responsibility of the employee to keep the Office of Human Resources advised of his or her current address and maintain communication. Any employee notified of a vacancy must report for duty within five (5) calendar days. Failure to report for duty shall be determined as an election not to report, and employment shall be terminated in accordance with Board policy and/or State law.

Unauthorized Absence
An employee who fails to return from a worker’s compensation leave on the date the employee is released by their doctor to work, may be terminated on the same basis as any other employee who fails to report to work or is absent without leave, unless the employee offers a legitimate and acceptable reason for not returning.

Indefinite Leave of Absence
The District shall not terminate an employee who is on unpaid leave of absence receiving worker’s compensation benefits, except, however, when the termination is for a legitimate reason independent from the employee’s worker’s compensation claim.

Transitional Duty / Return to Work
South San Antonio ISD has established a Transitional Duty Program to return occupationally injured employees to productive work as soon as possible following an on-the-job injury. The program allows an injured employee with medically indicated restrictions, to work gainfully and productively at their level of ability while recovering. The Transitional Duty process may involve modifying the regular job or if available, providing temporary alternative work, possibly at an alternative work location.

The intent of this Administrative Regulation is to establish uniform guidelines regarding Transitional Duty assignments. The following procedures in no way obligates or guarantees placement where one is neither available nor mutually beneficial to the employee and District.

Modified Duty
The District may assign modified duty to an employee who has sustained a work-related injury and has been given work restrictions by the attending physician. The Office of Human Resources is authorized to establish and administer the modified duty program. The campus Principal and/or the Department Director will be contacted by Human Resources to determine whether the injured employee will be able to be accommodated to return to work with the restrictions placed by the physician. Employees who are NOT accommodated to return to work due to the restrictions must be placed on FMLA or TDL, provided the employee qualifies for the leave.
The District shall, on the written request of the employee, a doctor, the insurance carrier, or the TDI, notify the employee, the employee’s treating doctor if known to the District, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the District. If those opportunities or that program exists, the District shall provide other information to assist the doctor, the employee, and the insurance carrier to assess modified duty or return-to-work options.

**ELIGIBILITY**
All SSAISD employees, injured on the job, with medically indicated restrictions preventing their return to regular duty.

**TRANSITIONAL DUTY**

- Employees shall seek appropriate medical treatment form the health care provider of their choice who accepts occupational injury patients.
- Report immediately to the Human Resources Department after each doctors’ appointment with their current Work Status form. If appointment is after normal work hours, report at 8:00 am the next workday.
- The Human Resources Department shall assess information from employee’s health care provider concerning the abilities, restriction(s), position available and/or risk to the employee, fellow employees, students or public before a Transitional Duty position is offered. Assessment will also include the ability to perform the essential functions of the position.
- The Human Resources Department will confer with the appropriate campus/department administrator prior to extending an offer of Transitional Duty.
- Primary effort will always be to accommodate employees through job modification of their original position. If restrictions prevent placement within the original position, an injured employee may be given tasks or duties within the same department or at an alternative site.
- If the campus/department is unable to accommodate an injured worker, the worker may be placed at an alternative site. Should alternative site placement occur, the campus/department shall remain financially responsible for the employee during their Transitional Duty assignment.
- Once a position is established, a *Bona Fide offer of Employment* will be extended to employee.
- If an employee refuses to accept a Transitional Duty assignment, within the capabilities as outlined by the health care provider, the employee shall be disqualified from participating in the Transitional Duty program and their employment status with the District and entitlement to Workers’ Compensation benefits may be impacted.
- The Human Resources Department will provide the appropriate campus/department with written documentation supporting the Transitional Duty assignment.
- If Transitional Duty is not available, the employee shall remain off work and will receive weekly indemnity benefits, if eligible.
At any time during the Transitional Duty assignment, the Human Resources Department may refuse/remove an employee from their assignment if there is a safety concern and/or for reasons of operational necessity.

Transitional Duty assignment shall not exceed a total of thirty (30) working days (approximately six weeks), unless a variance or extension has been approved by the Human Resources Department. After thirty (30) working days on Transitional Duty, the employee shall return to their position or be placed on a weekly Workers’ Compensation indemnity benefits, if eligible.

Employee assigned to Transitional Duty will earn their regular rate of pay for hours worked. If restrictions mandate less than regularly scheduled number of hours, they will receive partial weekly Workers’ Compensation indemnity benefits to cover the lost hours, if eligible.

All Transitional Duty assignments are temporary in nature, no entitlement or property rights exist. These assignments are not meant to be construed as permanent placement/transfers.

All other District benefits shall continue while an employee is on Transitional Duty. Employees on Transitional Duty may take any available leave/vacation subject to compliance with District policy.

**RESPONSIBILITIES**

**Human Resources Department Responsibilities**

- Administration of the Transitional Duty program.
- Confer with campus/department administrator regarding restrictions and/or abilities of injured worker.
- Collaborate as needed with campus/department staff regarding the structure of Transitional Duty assignments.
- In conjunction with Workers’ Compensation claim administrator ensure health care providers are aware of the Transitional Duty program.
- Maintain contact with the employee, health care provider, claims administrator to facilitate earliest and most effective return to work.

**Campus/Department Responsibilities**

- Identify potential Transitional Duty assignments through job restructuring, fragmentation or modification.
- Advocate Transitional Duty program through exhibiting openness to accommodations via creativity in structuring assignments that support campus/department overall mission.
- Monitor and communicate with Transitional Duty employees to insure they are working within restrictions.
- Consult with Human Resources Department should safety or management issues arise regarding medical restrictions or Transitional Duty assignment.
- Assure that injured employees have obtained proper authorization to return to work from the Human Resources Department.
Employee Responsibilities
- Inform health care provider of Transitional Duty program and District’s ability to accommodate physical restrictions.
- Report immediately to the Human Resources Department after each doctor’s appointment with their Work Status form. If appointment is after normal work hours, report at 8:00 am the next workday.
- Accept or decline the Transitional Duty offer contained in the SSAISD Workers’ Compensation offer of employment. Refusal to accept offer may affect benefit entitlement and employment status.
- Follow safety rules and guidelines.
- Follow medical and work restrictions.
- Notify their supervisor, if they cannot perform the Transitional Duty assignment.
- Agree to perform all duties, i.e. keep appointments, as outlined by the health care provider and comply with the Transitional Duty program.
- Avoid activities inconsistent with health care provider’s instructions.
- If working Transitional Duty or losing time, employee must sign the Workers’ Compensation Procedures Form.
- Injured employee must obtain authorization to return to work from the Human Resources Department.

Injured Employee’s Responsibility
A South San Antonio Independent School District employee injured on-the-job is required to comply with District and/or Texas Workers’ Compensation Commission policies and procedures.

- The employee must not perform work, either full or part-time, either for pay or otherwise, for an employer or for his or herself, in violation of medical restrictions when he or she is off-duty or on Transitional Duty.
- The employee must not falsify or misrepresent his or her physical condition or disability. The employee will do everything within the doctor’s orders to get back to work as soon as possible.
- The employee must follow the work restrictions and/or instructions provided by the treating physician, whether he or she is off-duty or working Transitional Duty, and will not do anything that could aggravate or reinjure themself.
- The employee must report to his or her supervisor any activity that may aggravate their injury.
- The employee must report for examinations and treatment as directed by their treating physician or the Texas Worker’s Compensation Commission.
- If offered, the employee will return to regular or transitional duty when authorized by the treating physician.
- The employee must report to the SSAISD Human Resources Department, 5622 Ray Ellison Blvd., San Antonio, Texas 78242, Phone 210-977-7042 immediately following each doctor’s visit.
• The employee must **immediately** notify the SSAISD Human Resources Department, Phone 977-7042, if he or she is unable to work.

• The employee must contact his or her assigned JJ Specialty Services adjuster on a weekly basis while the employee is off duty at 800-580-5477.

• The employee must contact the SSAISD Human Resources Office at 210-977-7042 to request a Leave of Absence (LOA) if out more than five (5) consecutive workdays.

• The employee must follow established safety rules and report any hazardous or unsafe conditions to his or her supervisor.

**Claims Administrators Responsibilities:**

• Inform health care provider of Transitional Duty program and District’s ability to accommodate injured workers.

• Monitor injured worker’s medical progress through systematic telephone contact with employee and medical provider while providing District contact with pertinent information that may lead to return to work.

• Immediately contact Human Resources Department when notified health care provider released employee to work with restrictions.

• Contact health care provider to clarify ambiguities in work release restrictions.

• Present where applicable, Workers’ Compensation Procedures (Attachment A) for employee signature.
WHAT TO DO WHEN AN EMPLOYEE SUFFERS
A Work Related Injury

Injured Employee – notifies supervisor and completes required forms and reports to Human Resources Department.


Supervisor – immediately contacts Human Resources at 210-977-7042 and submits all completed paperwork via email to ipaine@southsanisd.net or fax at 210-977-7017.

Injured Employee – obtains medical treatment and receives “DWC 73” work status report from physician; employee returns to Human Resources to obtain “Authorization to Report to Work”.

Supervisor – receives doctor’s work status report and “Authorization to Report to Work” form from Human Resources. Supervisor determines if employee is able to be accommodated; supervisor signs and returns the form to the Human Resources. Supervisor cannot allow an injured employee on the job without clearance from Human Resources.

Injured Employee – Signs bona fide letter of employment or takes leave if unable to return to work; leave/pay offset form must be signed.

SSAISD Police is contacted if EMS assistance is medically necessary.

Employees may elect to receive treatment at an urgent care clinic or physician who accepts WC.

Workers’ Compensation is a pay benefit and not an approved leave. Employees MUST contact the Office of Human Resources to obtain leave authorization, if needed.
Required Forms

1) Employee First Report of Injury Illness
2) Employee’s on-the-job Accident Report
3) Body Diagram
4) Supervisors Accident Investigation Report
5) Witness Statement
6) Workers’ Compensation Frequently asked Questions
7) Transitional Duty/Return to Work Policy
8) Workers’ Compensation Procedures – Attachment A
9) Bona Fide Letter of Employment (issued by Human Resources)
10) Leave/Pay Offset Form (issued by Human Resources)
11) FMLA Paperwork (issued by Human Resources)
12) Recalculation Acknowledgement Form (issued by Human Resources)
13) HIPAA Form (Issued by Human Resources)
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.

**CLAIM #**

**CARRIER'S CLAIM #**

**EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name (Last, First, M.I.)</td>
<td></td>
</tr>
<tr>
<td>2. Sex</td>
<td>M</td>
</tr>
<tr>
<td>3. Social Security Number</td>
<td></td>
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<tr>
<td>4. Home Phone</td>
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<tr>
<td>5. Date of Birth (m-d-y)</td>
<td></td>
</tr>
<tr>
<td>6. Does the Employee Speak English?</td>
<td>YES</td>
</tr>
<tr>
<td>7. Race</td>
<td>White</td>
</tr>
<tr>
<td>8. Ethnicity</td>
<td>Hispanic</td>
</tr>
<tr>
<td>9. Marital Status</td>
<td>Married</td>
</tr>
<tr>
<td>10. Number of Dependent Children</td>
<td></td>
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<tr>
<td>11. Supervisor's Name</td>
<td></td>
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<tr>
<td>12. Doctor's Name</td>
<td></td>
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<tr>
<td>13. Employer's Address (Street or P.O. Box)</td>
<td></td>
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<tr>
<td>14. City</td>
<td></td>
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<tr>
<td>15. State</td>
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<td>16. Zip Code</td>
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<tr>
<td>17. County</td>
<td></td>
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<tr>
<td>18. Date of Injury (m-d-y)</td>
<td></td>
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<tr>
<td>19. Time of Injury</td>
<td></td>
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<tr>
<td>20. Date Lost Time Began (m-d-y)</td>
<td></td>
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<tr>
<td>21. Nature of Injury</td>
<td></td>
</tr>
<tr>
<td>22. How and Why Injury Occurred</td>
<td></td>
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<tr>
<td>23. Was employee working for regular pay?</td>
<td>YES</td>
</tr>
<tr>
<td>24. Worksite Location of Injury (stairs, dock, etc.)</td>
<td></td>
</tr>
<tr>
<td>25. Address Where Injury or Exposure Occurred</td>
<td></td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>26. Address Where Injury or Exposure Occurred</td>
<td></td>
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<tr>
<td>27. Employer's Name</td>
<td></td>
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<tr>
<td>28. Employer's Address (Street or P.O. Box)</td>
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<tr>
<td>29. City</td>
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<td>30. State</td>
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<td>31. Zip Code</td>
<td></td>
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<td>32. Date Reported (m-d-y)</td>
<td></td>
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<tr>
<td>33. Date of Hire (m-d-y)</td>
<td></td>
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<tr>
<td>34. Employee's Payroll Classification Code</td>
<td></td>
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<tr>
<td>35. Occupation of Injured Worker</td>
<td></td>
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<tr>
<td>36. Rate of Pay at Time of Injury</td>
<td></td>
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<td>37. Weekly Pay Rate</td>
<td></td>
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<tr>
<td>38. Days Lost Pay Roll</td>
<td></td>
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<tr>
<td>39. Yes, employee lost</td>
<td></td>
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<tr>
<td>40. Last Day Paid</td>
<td></td>
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<tr>
<td>41. Name of Business</td>
<td></td>
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<tr>
<td>42. Business Address and Telephone Number</td>
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<tr>
<td>43. Business Location (if different from mailing address)</td>
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<tr>
<td>44. City</td>
<td></td>
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<tr>
<td>45. State</td>
<td></td>
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<tr>
<td>46. Zip Code</td>
<td></td>
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<tr>
<td>47. Telephone Number</td>
<td></td>
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<tr>
<td>48. Employer's Name</td>
<td></td>
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<tr>
<td>49. Employer's Address</td>
<td></td>
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<tr>
<td>50. Name and Title of Person Completing Form</td>
<td></td>
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<tr>
<td>51. Yes, employee lost</td>
<td></td>
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<tr>
<td>52. Last Day Paid</td>
<td></td>
</tr>
<tr>
<td>53. Yes, employer</td>
<td></td>
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</tbody>
</table>

**DIVISION OF WORKERS' COMPENSATION**

12 | Page
EMPLOYEE’S ON THE JOB ACCIDENT REPORT

The questions below are pertaining to your on-the-job injury. If the question does not pertain to you, write “N/A”. Please complete to the best of your knowledge and return to your supervisor WITHIN 48 HOURS of an injury.

Las siguientes preguntas pertenecen a su lastimadura del trabajo. Si la pregunta no le pertenece marque “N/A”. Favor de contestar las preguntas, lo mejor de su conocimiento y entregue este reporte a su supervisor dentro de 48 horas de una lastimadura.

Name/Nombre: ________________________________________________
Address/Domicillo: ____________________________________________
Social Security No./No. de Seguro Social: ____________________________
Telephone/Telefono: ____________________________________________
Occupation/Ocupacion: __________________________________________
Date and time of Injury/Fecha y hora de lastimadura: _____/_____/___________:_____am/_____pm
Location of Accident/Localidad de Accidente: ____________________________
Supervisor’s Name/Nombre de su supervisor: ____________________________

1. Has the accident been reported to your supervisor? Le reporto este accidente a su supervisor? Yes/Si ___ No __
2. Were you injured? Se lastimo? Yes/Si ___ No ___
3. Did you see a doctor? Consulto a un Doctor? Yes/Si ___ No ___
   If yes, when? Si la respuesta es “si”, cuando? Date/Fecha ________________________________
4. At what location within the facility did the incident occur (kitchen, classroom #, hallway, outside, etc. be specific? Indique con detalle el area donde ocurrio su accidente dentro del edificio (cocina, aula, pasillo, afuereaa, etc.).
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
6. Which part(s) of your body did you injure? (be specific and mark the body parts on the attached diagram)
   Que parte(s) de su cuerpo se lastimo? (sea detallado y marque sus Lastimaduras sobre el diagrama Incluido).

7. In your opinion, what caused your accident?  En su opinion que causo su accidente?

8. What safety measures do you think can be taken to prevent an accident of this type?  Que medidas de seguridad piensa usted pueden tomarse para prevenir este tipo de accidente?

9. Do you have any prior injuries?  If yes, when and what part of the body did you injure?  A tenido alguna lastimadura anteriormente?  Si la respuesta es “si”, cuando y que parte del cuerpo se lastimo?
   Yes/Si  ___  No  ___  When?  Cuando?  ______________ What part of the body?  De que parte del cuerpo?

10. List any witnesses.  Proporcione nombre de testigos.
   1. __________________________________ Title/Titulo: ______________________________
   2. __________________________________ Title/Titulo: ______________________________
   3. __________________________________ Title/Titulo: ______________________________

The above answers are true and correct.  Las contestaciones son verdaderas y correctas.

I understand that after each visit to the doctor, I will obtain a copy of the Work Status Report (DWC 73) from the doctor and submit it to the Human Resources Department.

Entiendo que debo obtener una copia del reporte Work Status Report (DWC 73) del medico despues de cada visita.  Esta debe entregarse al departamento de Recursos Humanos.

_________________________________________________  __________________________
Signature/Firma                                      Date/Fecha

COMPLETE AND RETURN THIS FORM TO YOUR SUPERVISOR WITHIN 24 HOURS OF YOUR RECEIPT.
COMPLETE Y REGRESE ESTA FORMA A SU SUPERVISOR DENTRO DE 24 HORAS DE SU RECIBO.
SUPERVISORS ACCIDENT INVESTIGATION REPORT

Instructions: Supervisors should investigate the accident as soon as it is reported by the employee, but no later than the end of the workday or shift. A copy of the investigation is to be forwarded to the Human Resources Department within 48 hours of the accident. This form is to be completed by supervisors only.

Supervisor Name: ________________________________ Location: __________________________

Employee Name: ________________________________ Occupation: __________________________

Date and Time of incident: Incident reported to you:

1/1/2023 1:00 pm

1. Location of incident within the facility (kitchen, classroom #, hallway #, outside (where?), etc.) be specific:

2. Did the employee seek medical treatment from a doctor or nurse? □ Yes/ □ No If No, explain:

3. Did the employee report any injuries? □ Yes/ □ No (List the specific body parts affected):

4. What happened? Describe the incident as it was reported to you:

5. What was the cause of the accident? Determine the cause by analyzing all the factors concerned. If either the injured person, a machine or other physical condition was involved find out how and why.
A. Describe any unsafe acts:

B. Describe any unsafe conditions:

C. Fundamental cause:

6. What have you done or recommend be done to prevent a recurrence of this type of accident?

7. If any witnesses were listed in the Employee’s On-The-Job Accident Report, each witness must complete the attached witness statement.

Supervisor Signature: ________________________________ Date: ________________
WITNESS STATEMENT/TESTIMONIO DE TESTIGO

The questions below are pertaining to an on-the-job injury. Please complete to the best of your knowledge and return to your supervisor. Las siguientes preguntas pertenecen a una lastimadura del trabajo. Favor de contestar las preguntas, lo major de su conocimiento y estregue este reporte a su supervisor.

Campus or Department/Escuela o Departamento: ________________________ Date/Fecha: __________

Name/Nombre: __________________________________________________________________________

Address/Direccion: _______________________________________________________________________

Telephone/Telefono: (____) ______-_________ Work phone/Telefono de Trabajo: (____) ______-____

1. Description of the incident/Descripción de incidente: ________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________
   _______________________________________________________________________________________

2. Where you located in conjunction with the incident/Estaba usted localizado en conjunto en el incidente?
   _______________________________________________________________________________________
   _______________________________________________________________________________________

3. Did you witness the event while it was happening or afterwards/Usted fue testigo del accidente mientras ocurria o despues de que ocurio? _______________________________________________
   _______________________________________________________________________________________

4. Do you have anything you wish to add to this statement/Desea agregar algo mas a este testimonio?
   _______________________________________________________________________________________
   _______________________________________________________________________________________

____________________________________________________________

Signature/Firma Date/Fecha
SOUTH SAN ANTONIO INDEPENDENT SCHOOL DISTRICT
DEPARTMENT OF HUMAN RESOURCES
5622 Ray Ellison Boulevard • San Antonio, Texas 78242-2214 • (210) 977-7042 • Fax (210) 977-7017

Employee's on-the-job Accident Report

Workers' Compensation Date of Injury: __________________________ Fecha de lastimadura: ________________
Name of Injured Employee/Nombre: ________________________________________________

Mark your injuries with an "X" on the diagram(s).
Marque sus lastimaduras con una "X" sobre el diagram indicado.
WORKERS’ COMPENSATION
FREQUENTLY ASKED QUESTIONS

1. **What is Worker’s Compensation?**

   Worker’s Compensation is a state-regulated insurance program that pays *reasonable and necessary medical costs* if you have a compensable on-the-job injury.

2. **What should I do if I’m injured on the job?**

   - You must **immediately notify your supervisor** and report the injury. The injury must be reported even if you are not seeking medical treatment at this time.
   - You must then fill out The Employees Questionnaire (provided by your supervisor)
   - Your supervisor must fill out the supervisor's accident investigation report and the Employers First Report of Injury/Illness
   - All reports must be submitted **immediately** to the Human Resources Department for processing of the claim to fax: (210) 977-7017
   - For immediate medical attention contact SSAISD Human Resources Department at (210) 977-7042.

3. **What should I do if I am injured on the job and my supervisor is not available?**

   Report the injury immediately to Human Resources Department at (210) 977-7042.

4. **Can I use my regular health insurance to cover a work related injury?**

   No. If you are injured on-the-job report it immediately and contact the SSAISD Human Resources Department *prior* to seeking medical attention.

5. **Why do I have to use my own local/state days when I was injured at work?**

   Workers’ compensation income benefits are regulated by the State of Texas including the maximum amount, and when benefits begin. Since South San Antonio ISD operates on tax dollars (public funds), the District can only pay employees for day they actually work or if they exchange a state or personal day of their absence.

6. **What is a DWC 73?**
The DWC 73, also called the work status report, is the form your doctor fills out that describes which duties of your job you can do safely such as lifting, standing, and driving.

7. **What if my doctor states I can go back to work, but I don’t think I can?**

If the District makes a bona fide offer of employment, and you chose not to take the offer, you may lose your Temporary Income Benefits.

8. **What exactly is a bona fide offer of employment?**

This is an employer letter offering modified or alternate work to an employee within his/her medical restrictions.
TRANSITIONAL DUTY/RETURN TO WORK POLICY

STATEMENT OF PURPOSE

South San Antonio ISD has established a Transitional Duty Program to return occupationally injured employees to productive work as soon as possible following an on-the-job injury. The program allows an injured employee with medically indicated restrictions, to work gainfully and productively at their level of ability while recovering. The Transitional Duty process may involve modifying the regular job or if available, providing temporary alternative work, possibly at an alternative work location.

The intent of this Administrative Regulation is to establish uniform guidelines regarding Transitional Duty assignments. The following procedures in no way obligates or guarantees placement where one is neither available nor mutually beneficial to the employee and District.

ELIGIBILITY

All SSAISD employees, injured on the job, with medically indicated restrictions preventing their return to regular duty.

RESPONSIBILITIES

1.0 **Human Resources Department Responsibilities:**

1.1. Administration of the Transitional Duty program.

1.2. Confer with campus/department administrator regarding restrictions and/or abilities of injured worker.

1.3. Collaborate as needed with campus/department staff regarding the structure of Transitional Duty assignments.

1.4. In conjunction with Workers’ Compensation claim administrator insure health care providers are aware of the Transitional Duty program.

1.5. Maintain contact with the employee, health care provider, claims administrator to facilitate earliest and most effective return to work.

2.0 **Campus/Department Responsibilities:**

2.1. Identify potential Transitional Duty assignments through job restructuring, fragmentation or modification.

2.2. Advocate Transitional Duty program through exhibiting openness to accommodations via creativity in structuring assignments that support campus/department overall mission.

2.3. Monitor and communicate with Transitional Duty employees to insure they are working within restrictions.
2.4. Consult with Support Services/Human Resources Department should safety or management issues arise regarding medical restrictions or Transitional Duty assignment.

3.0 Employee Responsibilities:
3.1. Inform health care provider of Transitional Duty program and District’s ability to accommodate physical restrictions.
3.2. Report immediately to the Human Resources Department after each doctor’s appointment with their Work Status form. If appointment is after normal work hours, report at 8:00 am the next workday.
3.3. Accept or decline the Transitional Duty offer contained in the SSAISD Workers’ Compensation offer of employment. Refusal to accept offer may affect benefit entitlement and employment status.
3.4. Follow safety rules and guidelines.
3.5. Follow medical and work restrictions.
3.6. Notify their supervisor, if they cannot perform the Transitional Duty assignment.
3.7. Agree to perform all duties, i.e. keep appointments, as outlined by the health care provider and comply with the Transitional Duty program.
3.8. Avoid activities inconsistent with health care provider’s instructions.
3.9. If working Transitional Duty or losing time, sign off on Workers’ Compensation Procedures (Attachment A).

4.0 Claims Administrators Responsibilities:
4.1. Inform health care provider of Transitional Duty program and District’s ability to accommodate injured workers.
4.2. Monitor injured worker’s medical progress through systematic telephone contact with employee and medical provider while providing District contact with pertinent information that may lead to return to work.
4.3. Immediately contact Human Resources Department when notified health care provider released employee to work with restrictions.
4.4. Contact health care provider to clarify ambiguities in work release restrictions.
4.5. Present where applicable, Workers’ Compensation Procedures (Attachment A) for employee signature.

TRANSITIONAL DUTY PROCEDURE
1. Employees shall seek appropriate medical treatment form the health care provider of their choice who accepts occupational injury patients.
2. Report immediately to the Human Resources Department after each doctors’ appointment with their current Work Status form. If appointment is after normal work hours, report at 8:00 am the next workday.
3. The Human Resources Department shall assess information from employee’s health care provider concerning the abilities, restriction(s), position available and/or risk to the employee, fellow employees, students or public before a Transitional Duty position is offered. Assessment will also include the ability to perform the essential functions of the position.
4. The Human Resources Department will confer with the appropriate campus/department administrator prior to extending an offer of Transitional Duty.
5. Primary effort will always be to accommodate employees through job modification of their original position. If restrictions prevent placement within the original position, an injured employee may be given tasks or duties within the same department or at an alternative site.

6. If the campus/department is unable to accommodate an injured worker, the worker may be placed at an alternative site. Should alternative site placement occur, the campus/department shall remain financially responsible for the employee during their Transitional Duty assignment.

7. Once a position is established, a Bona Fide offer of Employment will be extended to employee.

8. If an employee refuses to accept a Transitional Duty assignment, within the capabilities as outlined by the health care provider, the employee shall be disqualified from participating in the Transitional Duty program and their employment status with the District and entitlement to Workers’ Compensation benefits may be impacted.

9. The Human Resources Department will provide the appropriate campus/department with written documentation supporting the Transitional Duty assignment.

10. If Transitional Duty is not available, the employee shall remain off work and will receive weekly indemnity benefits, if eligible.

11. At any time during the Transitional Duty assignment, the Human Resources Department may refuse/remove an employee from their assignment if there is a safety concern and/or for reasons of operational necessity.

12. Transitional Duty assignment shall not exceed a total of thirty (30) working days (approximately six weeks), unless a variance or extension has been approve by the Human Resources Department. After thirty (30) working days on Transitional Duty, The employee shall return to their position or be placed on a weekly Workers’ Compensation indemnity benefits, if eligible.

13. Employee assigned to Transitional Duty will earn their regular rate of pay for hours worked. If restrictions mandate less than regularly scheduled number of hours, they will receive partial weekly Workers’ Compensation indemnity benefits to cover the lost hours, if eligible.

14. All Transitional Duty assignments are temporary in nature, no entitlement or property rights exists. These assignments are not meant to be construed as permanent placement/transfers.

15. All other District benefits shall continue while an employee is on Transitional Duty. Employees on Transitional Duty may take any available leave/vacation subject to compliance with District policy.

________________________________________  ____________________
Employee’s Signature            Date
As a South San Antonio Independent School District employee injured on the job, there are requirements to comply with District and/or Texas Workers' Compensation Commission policies. Please read each and acknowledge by initialing in the space provided.

1. I will not perform work, either full or part-time, either for pay or otherwise, for an employer or for myself, in violation of medical restrictions when I am off-duty or on Transitional Duty.

2. I will not falsify or misrepresent my physical condition or disability. I will do everything within my power to get back to work as soon as possible.

3. I will follow the work restrictions and/or instructions provide by my treating physician, whether I am off-duty or working Transitional Duty, and will not do anything that could aggravate or reinjure myself.

4. I will report to my supervisor any activity that aggravates my injury.

5. I will report for examinations and treatment as directed by my treating physician or the Texas Worker’s Compensation Commission.

6. If offered I will return to regular or transitional duty when authorized by my treating physician.

7. I will report to the SSAISD Human Resources Department, 5622 Ray Ellison Blvd., San Antonio, Texas 78242, Phone 210-977-7042 immediately following each doctor's visit.

8. I will immediately notify the SSAISD Human Resources Department, Phone 977-7042, if I am unable to work.

9. I will contact my assigned JI Specialty Services adjuster on a weekly basis while I am off duty at 800-580-5477.

10. I will contact the SSAISD Human Resources Office at 210-977-7042 to request a Leave of Absence (LOA) if out more than five (5) consecutive workdays.

11. I will follow established safety rules and report any hazardous/unsafe conditions to my supervisor.

I have read each of the above procedures and my signature below acknowledges my responsibility as an employee of South San Antonio ISD. I understand failure to follow these procedures may impact my employment and Workers’ Compensation Benefits.

Print Name: ________________________________ Date: ________________ ID#___________

Employee's Signature: ________________________________ Campus ____________________
Policy References

CRD Legal – Insurance and Annuities – Health and Life Insurance
DEC Legal – Compensation and Benefits – Leaves and Absences
DEC Local – Compensation and Benefits – Leaves and Absences
DECA Legal – Leaves and Absences: Family and Medical Leave
CRE Legal – Insurance and Annuities – Workers’ Compensation