Report of Occupational Injury/Illness

FORM MUST BE FULLY COMPLETED WITHIN 48 HOURS OF AN INJURY

Name:	Social Security:	Campus/Department	Job Position

Employee's Home Address:

City-State-Zip:	Mobile Phone:

Date of Birth:	Sex:	Status: ❒Married ❒Single ❒Widowed ❒Divorced ❒Separated	Supervisor's Name:
Number of Dependent Children:		Spouse's Name	Has the Accident been reported to your supervisor? Yes❒ No❒

ACCIDENT INFORMATION (Must be completed by injured employee)

Date of Accident:	Location (hallway, classroom #, cafeteria, etc) & Campus BE SPECIFIC:	Time: ❒ am ❒ pm

In your own words, describe in detail how the accident occurred(use another sheet if needed):

Shade in all the areas of discomfort on the figure.

FRONT / BACK: Neck, Shoulder, Chest, Elbow, Upper Back, Wrist/Hand, Lower Back, Hip/Thigh, Knee, Lower Leg, Ankle/Foot

Using the scale below, rate the discomfort for both the left and right side of the body area named in the box at right.

No Discomfort ← 1 2 3 4 5 6 7 8 9 10 → Worst Discomfort

Discomfort Area	**Right**	**Left**
Neck		
Shoulder		
Chest		
Elbow/Forearm		
Hand/Wrist		
Hip/Thigh		
Knee		
Lower Leg		
Ankle/Foot		
Other		
Total		

Have you ever injured these body parts before (please indicate date, body part, and treating physician below)?

Date:	Body Part:	Treating Physician:
Date:	Body Part:	Treating Physician:

Medical Statement (Must be completed by injured employee)

Employee must **CHECK ONE** of the boxes below and initial:

❒I am **declining** medical attention at this time.
Employee Initials: ______________

❒I am **seeking** medical attention at this time.
Employee Initials: ______

Was there a witness to your injury? If so, please indicate name/title:

I hereby certify that the information above is true and correct to the best of my knowledge. I further understand that any falsification of information regarding a work-related injury or illness may result in disciplinary action up to an including termination of employment.

Employee's Signature:	Date:
Principal/Supervisor Signature:	Date:

FAX form within 48 hours of the injury to 210-921-2185 or by email Benefits@southsanisd.net

AUG 2022

Form
Pre-DWC1

Report of Occupational Injury/Illness

Supervisor Section(Please complete to the best of your knowledge) Accident Investigation

Name of Injured Employee ________________________ **Date of Injury________________**

Name, Title & Phone# of person completing this section
Date, Time

Who was the incident first reported to?

Did the injured employee do something to cause or contribute to the incident?

Did another factor contribute to the accident/injury or illness?

Was a work order required to mitigate the hazard? **Work Order #**

If no, what actions were taken to correct/prevent future similar accidents/incidents?

Anything else you would like to add?

Witness Statement Section:

GENERAL INFORMATION

Witness Name:	**Witness Phone#:**	**Witness Campus/Dept:**	**Witness Job Position:**
Witness Address:	**Injured Employee Name:**	Date of Accident:	
Signature of Witness:	**Date & Time Witness Statement was taken:**		

Statement

FAX form within 48 hours of the injury to 210-921-2185 or by email Benefits@southsanisd.net

AUG 2022

South San Antonio ISD - Human Resources Department

Elect Leave Benefits with Workers' Compensation (Offset)

Name: ______________________ **Employee Number:** ______________

Position: ______________________ **Department/Campus:** ______________

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

______________________________ ______________________________

District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage *kh'cr r nkecdng+"as long as I am on **paid** leave"cpf 1qt"hco kn{"o gf kecn" ngcxg"*HO NC+. I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave"vj cv'ku"pqv'HO NC. I choose the following option:

- ❑ Kej qqug"\q"wug"qpn{"aaaaaaaa"f c{u"qh"cxckncdng"r ckf "ngcxg"cv'vj ku"vko g0
- ❑ I choose to use all available paid leave. During the first seven days my leave will be used" in full-day increments. I understand that once I begin to receive workers' compensation" weekly income benefits my leave will be used in partial-day increments to supplement" workers' compensation income benefits.
- ❑ I choose **PQV** to use any available paid leave at this time. I understand that I will not" receive any regular salary payments from South"Ucp"Cpvqpkq"KUF while"receiving weekly income benefits under workers' compensation. No available paid leave"will be deducted from my leave balance. I further understand that by selecting this option,"I will receive only workers' compensation income benefits for any absences resulting"from my work-related illness or injury, unless and until I communicate to the district a"change in my decision.

______________________________ ______________________________

Employee signature Date

=a dcfHUbhBch]WY:

South San Antonio ISD Employee Rights and Responsibilities, Procedures for Workers Compensation, Transitional Duty Policy, and Frequently Asked Questions are posted on the South San Antonio ISD website for your review at www.southsanisd.net on the Benefits page. Please contact the Office of Benefits in Human Resources at 210-977-7043 if further information is needed.

HIPAA AUTHORIZATION FORM

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, ______________________________,*(Name)*____________________,*(Date of Birth)*______________, *(SSN)* authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
   - **All healthcare providers who have provided healthcare to me.**
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.
   - **Claims Administrative Services, Inc.**
     P.O. Box 7500, Tyler, Texas 75711
   - **Texas Department of Insurance – Division of Workers' Compensation**
     7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1609
   - **Others:** ____________________________
3. Specific description of the protected health information that I authorize for disclosure:
   - **Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.**
   - **I further specifically authorize the disclosure of psychotherapy notes, if any.**
4. The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.
7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.
9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

Signature	Date

Name		
Address		
Phone Number	**SSN (Last 4 Digits Only)** XXX-XX-	**Date of Birth**

*Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508 **These laws apply to health plans, health care providers, and health care clearinghouses.