Sharyland Independent School District

Insurance Department Workers' Compensation Program

❖ Envíe el formulario completo por correo electrónico a la Especialista de seguros o por fax al 956-580-5224.

Formulario de reclamación del empleado de indemnización por una lesión relacionada con el trabajo
(DWC1)

El reclamo de compensación laboral debe ser presentado por el empleado lesionado o por una persona que actúe en nombre del empleado lesionado dentro de uno o dos días de la fecha de la lesión.

I. INFORMACIÓN DEL EMPLEADO LESIONADO

Nombre (Nombre, Segundo, Apellido)	**Número de Seguro Social**	**Fecha de nacimiento** (m / d /a)
Dirección (calle, ciudad/pueblo, estado, código postal, condado, país)		
Número de teléfono	**Correo electrónico**	**Sexo** ☐ Masculino ☐ Femenino
Raza / Etnicidad Blanca Negra o africana americana Hispano Orta asiática _____		
¿Hablas inglés? ☐ Sí ☐ No Si no, especifique el idioma		
Estado civil ☐ Casada ☐ Viudo ☐ Separado ☐ Soltero ☐ Divorciado		
Ubicación del campus / departamento:	**Horario programado:** __ _____AM / _____: _____PM	
Ocupación en el momento de la lesión	**Extensión del teléfono del trabajo:**	**Estado laboral** ☐ Tiempo completo ☐ Tiempo parcial
Dirección completa de la ubicación del campus o departamento:		
¿El empleado estaba haciendo un trabajo regular? ☐ Sí ☐ No		**Fecha de contratación** (m / d / a)

II. INFORMACIÓN SOBRE LESIONES

Naturaleza de la lesión (salto, caída, contusión, etc.)	**Fecha de la lesión** (m / d / a)	**Hora de la lesión**
Ubicación de la lesión (aula, gimnasio, pasillo, etc.)	**Causa de la lesión** (herramienta, mochila, silla, etc.)	
Testigo(s) de la lesión (lista por nombre)		
Describir la causa de la lesión, incluyendo cómo está relacionada con el trabajo		
Parte(s) del cuerpo afectada(s) **o expuesta(s) por la lesión**		

III. INFORMACIÓN DEL EMPLEADOR (en el momento de la lesión)

Nombre del empleador	**Dirección del empleador** (calle, ciudad/pueblo, estado, código postal, condado, país)
Número de teléfono del empleador	**Nombre del supervisor**

IV. INFORMACIÓN DEL MÉDICO ¿Desea ver a un médico? ☐ Sí ☐ No

Nombre del médico tratante	**Número de teléfono**
Dirección (calle, ciudad/pueblo, estado, código postal)	
¿Podría haberse evitado este accidente? ☐ Sí ☐ No	**En caso afirmativo, ¿cómo?**

Imprimir Nombre de la persona que llena este formulario en nombre del empleado lesionado _____ **Fecha** _____

Firma del empleado lesionado _____ **Fecha** _____

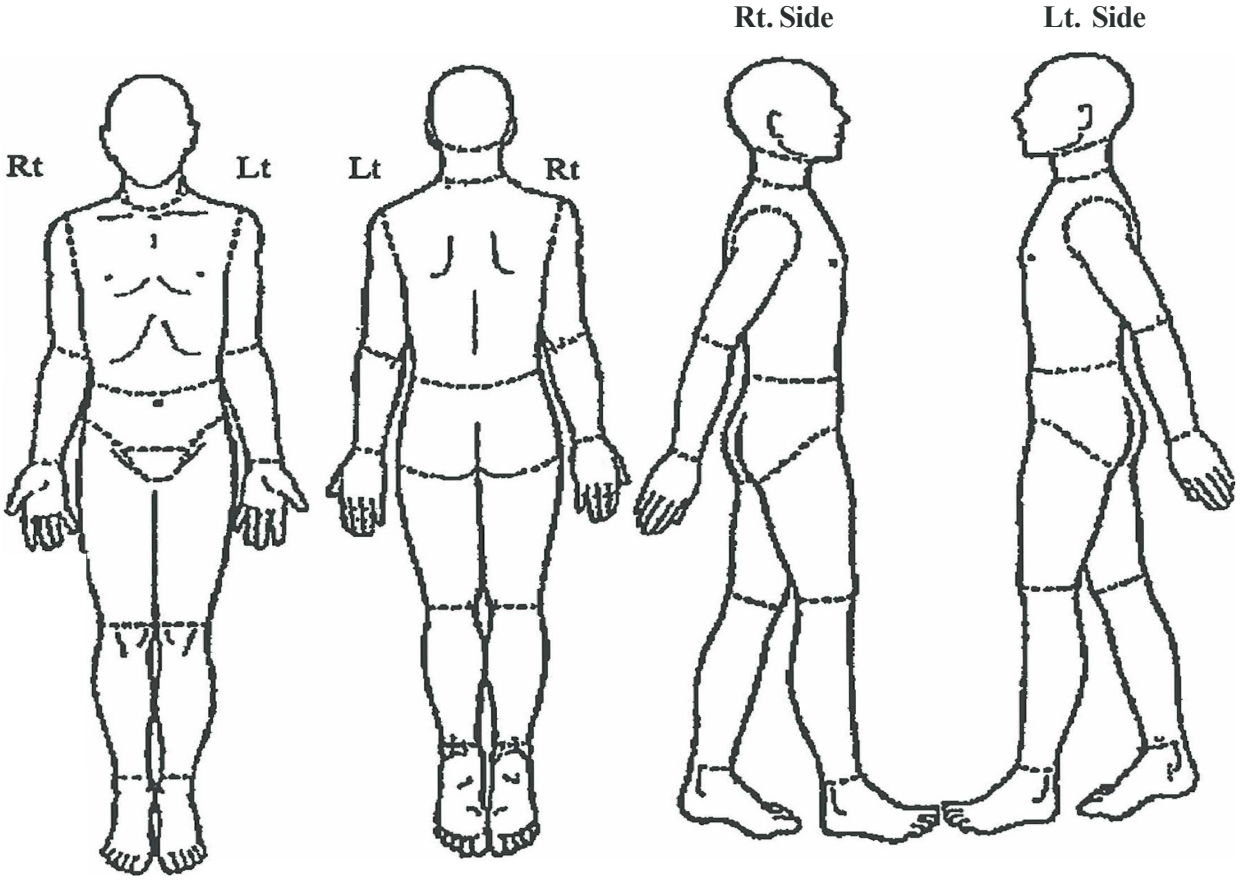
- **RECORDAR AL EMPLEADO:** DESPUÉS DE LA PRIMERA VISITA AL MÉDICO, EL EMPLEADO DEBE PRESENTARSE EN LA OFICINA DE COMPENSACIÓN PARA TRABAJADORES ANTES DE REGRESAR AL TRABAJO.
- EL EMPLEADO DEBE RECIBIR LA INFORMACIÓN SOBRE LOS DERECHOS Y LA RESPONSABILIDAD DEL EMPLEADO.
- SI EL EMPLEADO BUSCA TRATAMIENTO MÉDICO POR PARTE DEL MÉDICO, LA VERIFICACIÓN DE LA COBERTURA DE COMPENSACIÓN PARA TRABAJADORES DEBE ENTREGARSE AL EMPLEADO PARA QUE LO LLEVE AL CONSULTORIO MÉDICO Y A LA FARMACIA.

Sharyland Risk Management Program
Diagrama del cuerpo

Nombre: _____ Número de Seguro Social: XXX-XX- _____

Fecha de la lesion: _____

En el diagrama proporcionado a continuación, por favor. Circule las partes de su cuerpo donde experimenta dolor debido a esta lesión.



1. **Por la presente certifico que la información anterior a este formulario es verdadera y correcta a mi saber y entender.**
2. **Entiendo que cualquier falsificación de información con respecto a un trabajo o enfermedad puede resultar en una acción disciplinaria y/o enjuiciamiento bajo los Estatutos Penales Estatales apropiados.**

_____ _____

Firma del Empleado **Fecha**

Sharyland I.S.D.
Insurance Department / Workers' Compensation Program
1200 N. Shary Rd., Mission, TX 78572
956-580-5200 x 1108

VERIFICACIÓN DE COBERTURA DE COMPENSACIÓN PARA TRABAJADORES

Lleve este formulario al médico, visita al hospital o farmacia con receta

(Nombre)_____ha reportado una lesión/enfermedad relacionada con el trabajo que ocurrió el (Fecha)_____. Esto puede estar cubierto por los beneficios de Compensación para Trabajadores. Póngase en contacto con Tristar Risk Management en la dirección a continuación para autorizar un tratamiento médico razonable y necesario, y para presentar los gastos incurridos por esta reclamación.

Mail Claims to:
Tristar Risk Management
PO BOX 2805
Clinton, Iowa 52733-2805

Toll Free: 800- 593-0020 or Phone: (361) 857-0115
Fax: (361) 857-0123

Amy Kwast - Claim Supervisor
Amy.Kwast@tristargroup.net
ext. 2923

Terry Cherry - Claim Examiner III
Terry.Cherry@tristargroup.net
ext. 3014

Aracelia "Sally" Hernandez - Claims Examiner I
Aracelia.Hernandez@tristargroup.net
ext. 3015

Lizette Silguero - Claims Assistant
Lizette.Silguero@tristargroup.net
ext. 3011

Attention Doctor's Office

FAX

DWC73 to 956-580-5224
as soon as possible

TRISTAR®

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

The undersigned authorizes the medical provider designated below to disclose specified medical records to a designated recipient. The medical provider shall not condition treatment, payment, enrollment, or eligibility for benefits on the submission of this authorization.

The disclosure of records authorized herein is required for the administration of a claim. Medical

provider: _____

Patient name:_____
Medical record number: _____
Date of birth: _____
Address:_____
Telephone number: _____
Claim number: _____
Email:_____

Recipient name: TRISTAR through its Copy Service Agent
Recipient address: P.O. Box 2805, Clinton, IA 52733-2805
Recipient telephone number: (800)593-0020

Health information requested:
X All medical records.

Purpose: Processing / administration of _____'s workers' compensation claim.

Note: records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments and results of HIV tests will not be disclosed unless specifically requested (check all that apply):

___Mental health records.
___Alcohol or drug records.
___HIV test results.

Method of delivery of requested records:
___Mail
___Pick up
___Electronic delivery, recipient email:_____

This authorization is effective until the workers' compensation claim is fully resolved or unless a different date is specified here _____(Date).

This authorization may be revoked upon written request, but any revocation will not apply to information disclosed before receipt of the written request.

A copy of this authorization is as valid as the original. The undersigned has the right to receive a copy of this authorization.

Notice: Once the requested health information is disclosed, any disclosure of the information by the recipient may no longer be protected under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient signature*:_____
Date: _____
Print name: _____

*If not signed by the patient, please indicate relationship to the patient (check one, if applicable):

___Parent or guardian of minor patient who could not have consented to health care.
___Guardian or conservator of an incompetent patient.
___Beneficiary or personal representative of deceased patient.

Specialty	Facility	Name	Prof.Designation	OfficeAddress 1	OfficeAddress 2	OfficeCity	OfficeState	OfficeZIP	OfficePhone
Fam. Practice/Urgent Care	**Valley Day & Night Clinic**		**FP/UCC**	**305 E Expressway 83**		**Mission**	**TX**	**78572**	**956-585-7401**
Family Practice	**Industrial Health Works Family Day & Night Clinic**	**Bose, Ashley**	**MD**	**801 E Nolana**	**Suite 9**	**McAllen**	**TX**	**78504**	**956-668-7333**
Family Practice	**Family Physicians Clinic & Valley Night Clinic**		**Clinic**	**606 S Broadway**		**McAllen**	**TX**	**78501**	**956-682-4515**
Family Practice	**McAllen Primary Care Clinic/McAllen Family Urgent Care**	**Dr. Sergio Diaz**	**MD**	**110 East Savannah**	**A204**	**McAllen**	**TX**	**78503**	**956-686-4040**
General Practice	**Rio Occupational Institute, LLC**	**Dr. Mario Vasquez Aguila**	**MD**	**2501 Buddy Owens Blvd.**		**McAllen**	**TX**	**78504**	**956-631-6109**
Internal Med/Urgent Care	**Urgent Care 4 U**		**IM/UCC**	**6316 N 10th St.**	**Suite C1**	**McAllen**	**TX**	**78504**	**956-994-0111**
Ortho Surgery	McAllen Orthopedics Associates	Goldsmith, Gregory	MD / Orthopedics	110 E Savannah	Bldg. B-101	McAllen	TX	78503	956-686-1575
Physical / Occupational Therapy	Evolutions Therapy	Natasha Odendaal	OTR, OTD, CHT, CLT, C/NDT	5225 S. Mccoll Road		Edinburg	TX	78539	956-627-2142
Physical / Occupational Therapy	Evolutions Therapy	Janet Tan	PT, DPT	5225 S. Mccoll Road		Edinburg	TX	78539	956-627-2142
Physical Therapy	Puig Physical Therapy	Robert Puig	Phys Ther	2122 E Griffin Pkwy		Mission	TX	78572	956-585-8886
Physical Therapy	Puig Rehabilitation	Kevin Abers	Phys Ther	500 E Dove		McAllen	TX	78504	956-686-3434
Physical Therapy	Saffels	Nathan	PT	4865 N. McColl		McAllen	TX	78504	
Physical Therapy	Terry Physical Therapy		Phys Ther	1918 E Griffin Pkwy		Mission	TX	78572	956-583-2995
Radiology	Optimum Imaging Center		Imaging Center	500 S Bicentennial		McAllen	TX	78501	956-585-8700
Therapy & Rehab	Picasso Therapy & Rehab	Jose C. Picasso, DC	Therapy & Rehab	1001 E Griffin Pkwy		Mission	TX	78572	956-585-2225
Chiropractor	Tagle III	Pablo	Chiropractic	2215 Fern Avenue	Suite B	McAllen	TX	78501	956-686-8060

These Are The Only Doctors and/or Facilities That Are Approved For Workers' Compensation

PROCEDIMIENTOS DE PRESENTACIÓN DE INFORMES
Por incidentes o lesiones

Los empleados de Sharyland ISD están cubiertos por las disposiciones de la Ley de Compensación de Trabajadores de Texas a través de una póliza de auto seguro.

1. Si le ocurre una lesión o incidente a un empleado mientras está de servicio y el incidente o lesión es una **"emergencia",** llame a una ambulancia o lleve al empleado al hospital más cercano.

2. Es responsabilidad del supervisor inmediato, el custodio principal o el gerente de la cafetería **informar inmediatamente cualquier incidente / lesión al administrador o director del campus.**

3. La enfermera del campus o el secretario del departamento es responsable de obtener toda la información necesaria sobre el incidente / lesión de "**emergencia"** tanto del empleado como del personal del distrito. La enfermera / secretaria del campus presentará un "**Primer informe de lesión / incidente", "Formulario de diagrama corporal" y "Autorización para la divulgación de información de salud"** a la Oficina de Gestión de Riesgos por fax (**956-580-5224)** o correo electrónico (auribe@sharylandisd.org).

4. Si el incidente no es una emergencia, la enfermera y / o secretaria del campus obtendrán los primeros auxilios necesarios y evaluarán la necesidad de atención médica adicional. El empleado debe informar verbalmente el incidente a su supervisor tan pronto como sea posible, pero a más tardar **24 horas** después de la fecha del incidente / lesión. Los empleados de mantenimiento y transporte reportarán incidentes a la Secretaria de Mantenimiento, **Maricela Espinosa x 1076** o a la secretaria del departamento de Transporte, **Melissa Ybarra x 2810**. ***El incumplimiento dará lugar a medidas disciplinarias.***

5. Los empleados que requieren tratamiento médico adicional deben notificar a la **Oficina de Administración de Riesgos** antes del tratamiento para calificar para los beneficios médicos de Compensación para Trabajadores. ***Los empleados deben completar toda la documentación necesaria para una remisión a un médico aprobado por la compensación para trabajadores de la Lista de Médicos de la Red de Compensación para Trabajadores***.

6. Después del primer médico, los empleados de la visita deben informar a la Oficina de Gestión de Riesgos antes de regresar al trabajo.

7. Es responsabilidad del empleado informar o comunicarse con la **Oficina de Gestión de Riesgos** después de cada cita médica. Un empleado puesto en licencia por un período prolongado de tiempo debe hacer contacto personal con la **Oficina de Gestión de Riesgos** semanalmente durante la duración de la licencia médica. Si un empleado lesionado está ausente por más de cinco (5) días consecutivos, el empleado debe comunicarse con el Departamento de Recursos Humanos**.**

8. Los empleados deben adquirir un "Estado de Regreso al Trabajo" (**RTW)** de la **Oficina de Gestión de Riesgos antes de regresar al trabajo.**

9. Si tiene alguna pregunta o inquietud, no dude en llamar a la **Oficina de Risk Managemant al 580-5200**.

Mark Dougherty, Risk Manager – Ext. 1012
Angela Uribe, Workers Compensation / Insurance Specialist – Ext. 1108
Maricela Espinosa, Maintenance Secretary – Ext. 1076

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 (OIEC). 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 and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose 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. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. 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.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation 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 DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. 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. If there is something you do not understand, ask your employer or call OIEC. 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.texas.gov/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 providers 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 Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   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 DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**