BRAZOS COUNTY
HUMAN RESOURCES DEPARTMENT
200 S. TEXAS AVE SUITE 206, BRYAN,TX 77803
PHONE (979) 361-4181 FAX (979) 823-6993

Workers' Compensation Injury Checklist for Supervisors

Below is an abbreviated checklist which summarizes the county responsibilities when reporting an injury and ensures compliance with the Texas Labor Code.

When an Injury Occurs...

☐ Have the employee fill out the **Employee Report of Injury Form**. Discuss with the employee, if necessary, the facts of the accident.

☐ Supervisor completes the **Employer's First Report of Injury (DWC-1) form**. Do not ask the injured worker to complete this form. The DWC-1 is an employer-required form.

☐ Supervisor submits the completed **Employer's First Report of Injury (DWC-1) form** and the **Employee Report of Injury Form** to Human Resources via email HR@brazoscountytx.gov or fax 979-823-6993.

Items for the Injured Worker

☐ Human Resources will send a copy of the **DWC-1** and the following documents to the injured worker:

- ☐ **MyMatrixx Flyer** (serves as a temporary prescription card)
- ☐ **Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System**

Communication with the Medical Provider

☐ Ensure the provider is aware the accident is/was work-related. **The TAC RMP Notification of WC Coverage Provider** can be used for this purpose.

Questions concerning this document or injury reporting? Contact Human Resources at (979) 361-4181.

Workers' Compensation Injury and Claim Reporting Process
Brazos County

Work- related injury occurs and employee reports to a Supervisor

Supervisor must report any work-related injury or death to Human Resources immediately.

HR must file DWC-1 (First Report of Injury) with TAC RMP and the injured worker within 8 calendar days per Texas Labor Code §409.005.

If necessary, Supervisor must send injured worker to emergency facility or an Alliance Doctor. List available at www.pswca.org.

Law enforcement, EMS and Correctional Officer exposure to a Communicable Disease must be tested within 10 days.

Lost time beyond 7 days?

Yes

Wages must be reported to determine correct income benefit rate. The DWC-3 (Employers' Wage Statement) must be filed with TAC RMP and injured worker per Texas Labor Code §408.063.

County must pay full salary for Law Enforcement Officers.

No

Supervisor must report return to work date to HR. The DWC-6 (Supplemental Report of Injury) must be filed with TAC RMP and the injured worker within 3 days per Texas Labor Code §409.005.

Additional Lost Time?

Yes

Supervisor must report additional lost time to HR. The DWC-6 (Supplemental Report of Injury) must be filed with TAC RMP and the injured worker within 3 days of additional time off work per Texas Labor Code §409.005.

(512) 478-8753 • (800) 456-5974 • (512) 615-8942 FAX • www.county.org • 1210 San Antonio, Austin, TX 78701 • P.O. Box 2131, Austin, TX 78768-2131
Gene Terry, *Executive Director*

Workers' Compensation Injury and Claim Reporting Details

An injured worker must report an on the job injury to a supervisor or someone acting in a supervisory capacity within 30 days of the injury or within 30 days of the date the injured worker knew or should have known about an occupational illness.[1]

When an injury is reported, the employer is required to report it to the TAC (York Risk Services) on the **DWC-1, First Report of Injury** form within 8 calendar days[2]. Failure to file this form timely or properly can result in an Administrative Violation for the county in the event of an audit or complaint.

Depending on the severity of the injury, the supervisor should assist the injured worker with medical treatment. The injured worker may treat with a doctor or his or her choosing or must treat with an Alliance doctor if the county makes the Alliance mandatory for its employees. The provider list is located at www.pswca.org. Please ensure that the injured worker notifies his or her medical provider of the work-related incident to avoid medical bill filing with a healthcare insurance company.

Communicable Diseases and Required Testing

If the injured worker is a law enforcement officer, EMS employee, paramedic, fire fighter or correctional officer, and is exposed to any of the following communicable diseases, he or she is required to be tested for the following communicable diseases[3] within 10 days of the exposure.

"Acquired immune deficiency syndrome (AIDS); amebiasis; anthrax; botulism--adult and infant; brucellosis; campylobacteriosis; chancroid; chickenpox; Chlamydia trachomatis infection; cholera; cryptosporidiosis; dengue; diphtheria; ehrlichiosis; encephalitis; Escherichia coli 0157:H7; gonorrhea; Hansen's disease (leprosy); Heamophilus influenzae type b infection, invasive; hantavirus infection; hemolytic uremic syndrome (HUS); hepatitis, 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 fevers; and yellow fever."

This list of diseases may change from time to time. To determine the most current list of reportable diseases and exposure criteria refer to Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases.

Full Salary for Law Enforcement Officers

According to Texas Constitution Article 3 Section 52e, an opinion by the Texas Attorney General regarding detention officers, an appellate court's opinion regarding a specific case as presented by detention officers, and a Supreme Court opinion, counties are obligated to continue full salary for an injured law enforcement official.

Employee Resignation or Termination

The county is also required to report when an employee is terminated or resigns. The county has 10 days after the termination or resignation date to file a **DWC-6: Supplemental Report of Injury** with the TAC RMP Third Party Administrator, York Risk Services Group and the injured worker[4].

For more information concerning workers' compensation required claim reporting, contact _____.

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[1] Texas Labor Code §409.001

[2] Texas Labor Code §409.005

[3] Division of Workers' Compensation Rule §122.3

[4] DWC Rule §120.3

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ Social Security:_____ Gender: M / F
Last First MI Maiden

Address:_____ Date of Injury: _____

City: _____ State: _____ Employer:_____

Primary Phone Number: _____ Job Title: _____

Secondary Phone Number: _____ Work Schedule:_____

Email address: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date_____ Time_____

Name: _____ Title_____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone:_____

Name _____ Phone: _____ Name:_____ Phone:_____

7) Please identify your Primary Care Physician or family doctor: Name:_____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name:_____ Phone: _____

Name:_____ Phone:_____

Name:_____ Phone: _____

9) Has a doctor taken you off work? ___Yes ___ No If so, when was the first day you missed work ?_____

10) If the doctor took you off work, have you returned to work? ___Yes ___No If not, when do you think you will return to work?_____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ___Yes ___No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature:_____ Date:_____

TDI Division of Workers' Compensation

Complete if known:

DWC claim #

Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)		**2. Address** (street or PO box, city, state, ZIP code)	
3. Phone number	**4. Email address**	**5. Social Security number** (XXX-XX-XXXX)	**6. Date of birth** (mm/dd/yyyy)
7. Marital status		**8. Sex** ☐ Female ☐ Male ☐ Other	
9. Spouse's name (first, middle, last)		**10. Number of dependent children**	
11. Does the employee speak English? ☐ Yes ☐ No **If no, specify language**			
12. Doctor's name (first, last)		**13. Doctor's mailing address** (street or PO box, city, state, ZIP code)	

Part 2: Injury information

14. Date of injury or illness (mm/dd/yyyy)	**15. Time of injury** : ☐ a.m. or ☐ p.m.	**16. First day absent from work** (mm/dd/yyyy)
17. Supervisor's name (first, last)		**18. Date injury reported** (mm/dd/yyyy)
19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		**20. Body parts affected**
21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)		
22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)		
23. Was the employee doing their regular job? ☐ Yes ☐ No		
24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)		
25. List all witnesses (first, last names)		

26. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

27. Return-to-work date (mm/dd/yyyy) ☐ Actual date or ☐ Expected date	**28. Did the employee die?** ☐ Yes ☐ No If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)		**30. Occupation of injured employee**
31. Length of service in current position Years Months		**32. Length of service in current occupation** Years Months
33. Employee payroll classification code		**34. Was the employee hired or recruited in Texas?** ☐ Yes ☐ No
35. Rate of pay at this job $ Hourly $ Weekly	**36. Full work week is** Hours Days	**37. Last paycheck was** $ for Hours or Days

38. Is the employee an owner, partner, or corporate officer? ☐ Yes ☐ No

Part 4: Employer information

39. Name and title of person completing form (first, middle, last, title)	**40. Business name**	
41. Business mailing address (street or PO box, city, state, ZIP code)	**42. Phone number**	**43. Email address**
44. Business location (if different from mailing address)	**45. Federal employer identification number** 74-6000433	
46. Primary North American Industry Classification System (NAICS) code (six digits)	**47. Specific NAICS code** (six digits)	**48. Texas comptroller taxpayer number**
49. Workers' compensation insurance carrier Texas Assoc. of Counties Risk Management Po	**50. Policy number**	

51. Did you request accident prevention services in the past 12 months? ☐ Yes • No

If yes, did you receive them? ☐ Yes • No

Part 5: Certification

52. Certify with your signature:

I certify the information in this form is true and correct.

Signature_____ **Date**_____

FAQ
Employer's first report of injury or illness

Who do I send this form to?
Send this form to your workers' compensation insurance carrier and to the injured employee or the injured employee's representative. Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC), unless DWC specifically requests it.

When do I need to send this form?
You must send the DWC Form-001 within eight days after:

1. The employee's first day of absence from work due to the injury;
2. You receive notice of occupational disease; or
3. An employee dies.

Why do I need to send this form?
Employers must file this form so the insurance carrier has the information they need to begin the claims process. You may be fined if you fail to send this report without having a good reason (good cause.)

How should I send this form?
You can file the form with the insurance carrier and send it to the injured employee or the injured employee's representative by email, fax, U.S. Postal Service, or personal delivery.

Do I need to keep a copy of this form?
Yes, you should keep a copy of this form to serve as the Employer's Record of Injury required by Texas Labor Code Section 409.006. For more requirements refer to DWC rule 120.2, *Employer's first report of injury and notice of injured employee rights and responsibilities*.

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

Workers' Compensation Medical Provider Notice

To whom it may concern:

Brazos County is covered by The **Texas Association of Counties Risk Management Pool** for compensable workers' compensation injuries. The Pool contracts with **Sedgwick** to adjust its claims. All medical bills, reports and other supporting documentation may be submitted to the following address for consideration:

TAC Risk Management Pool - Sedgwick
P.O. Box 14152
Lexington, KY 40512-4152

800.752.6301
859.264.4061 (fax)

US-YORK-tacdwcforms@sedgwick.com

Please note, all bills are subject to retrospective review, reconsideration, and preauthorization under the Texas Workers' Compensation Act.

With the exception of emergency treatment, if the county participates in the Political Subdivision Workers' Compensation Alliance (Alliance), the treating doctor must be chosen from a list of Alliance doctors located at www.pswca.org. Please contact your adjuster at the number above for additional information.

MyMatrixx
By EVERNORTH

To the Injured Worker:

On your first visit, please give this form to any pharmacy listed on the back side to speed processing of your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the MyMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su primera visita, entregue este formulario a cualquier farmacia que se encuentre en el reverso del boleto para acelerar el procesamiento de sus recetas aprobadas para lesiones relacionadas con el trabajo (según las reglas establecidas por su empleador).

¿Tiene preguntas o necesita ayuda para localizar una farmacia participante? Llame al centro de contacto para pacientes de MyMatrixx al 800.945.5951.

Temporary Prescription Card

ID#: _____ sedgwick

Your SSN is your temporary ID. Present at Pharmacy.

RxBIN#: 003858

PCN: WC

RxGroup #: GJC7937

Date of Injury: _____
MM/DD/YYYY

For Workers' Compensation Only

WARN ME: OPIOIDS

Employee Information

_____
Full Name

_____
Street Address or PO Box

_____
City State ZIP

_____
Date of Birth

_____
Employer Name

To the Pharmacist:

MyMatrixx administers this administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $1500.00. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary.

For assistance, please call MyMatrixx at 888.786.9640.

Processing Steps:

1. Enter RxBin 003858
2. Enter PCN WC
3. Enter Rx Group Number GJC7937
4. Enter 9-digit member ID (Patient SSN)
5. Enter Date of Injury

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

MyMatrixx
By EVERNORTH

Participating Pharmacy List

AHF PHARMACY
AHOLD CORPORATION
ALBERTSONS
ALIGNRX LLC
AMERITA INC
AURORA PHARMACY INC
BIG Y FOODS INC
BI-LO HOLDINGS LLC
BROOKS/MAXI DRUG
BROOKSHIRE BROTHERS LTD
BROOKSHIRE GROCERY CO
CARDINAL HEALTH
CHEN NEIGHBORHOOD MEDI-CAL CENT
COBORN'S INC.
COSTCO WHOLESALE, INC
CVS CORP
DEDICATED US HOLDINGS LLC
DISCOUNT DRUG MART
ECKERD
EPIC PHARMACY NETWORK
ESSENTIA HEALTH
EXPRESS RX
FAIRVIEW PHARMACY SVCS
FAMILY FARE, LLC
FOOD LION PHARMACY
FRUTH PHARMACY
GENOA HEALTHCARE LLC
GIANT EAGLE PHARMACY
GUARDIAN PHARMACY LLC
HAC INC
HANNAFORD BROS. CO.
HARPS FOOD STORES INC
HARTIG DRUG
HEALTH MART ATLAS LLC
H-E-B LP
HENRY FORD HEALTH SYSTEM
HOMETOWN PHARMCY INC
HY-VEE FOOD STORES INC
INGLES MARKETS
INSTYMEDS CORP
KPH HEALTHCARE SERVICES
KS PHARM LLC
K-VA-T FOOD STORES INC
LEWIS DRUGS INC
LONGS DRUG STORE
MARC GLASSMAN INC
MEDICAP PHARMACY, INC.
MEDICINE SHOPPE
MEIJER PHARMACY
MERCY PHARMACY SERVICES
NCS HEALTHCARE
NEIGHBORCARE PHARMACY
OSBORN DRUGS INC
PATIENT FIRST
PHARMEDQUEST PHARMACY
PHARMERICA, INC
PMR US HOLDINGS
PRESBYTERIAN MEDICAL
PRESCRIBEIT RX
PRICE CHOPPER PHARMACY
PUBLIX SUPER MARKETS, INC
RALEY'S
RECEPT PHARMACY LP
RITE AID CORPORATION
SAFEWAY, INC.
SAM'S CLUB
SUPERVALU PHARMACIES, INC.
TARGET
THRIFTY WHITE STORES
TOPS MARKETS LLC
UNITED SUPERMARKETS INC
WALGREENS
WAL-MART
WEGMANS FOOD MARKETS,
WEIS MARKETS INC

Visit www.MyMatrixx.com to locate a participating pharmacy near you!

OFFICE OF INJURED EMPLOYEE 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 (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.**

RediMD™
get well sooner

Brazos County Workers' Compensation

Telemedicine Program

Injured employees can choose to see a doctor via

Telemedicine by calling:

888-REDIMD5 (733-4635)

24/7 Telemedicine Services for

Brazos County

Works with: Smart Phone, Tablets/I-pads,

Computer with a Webcam

and Internet connection

If you have any additional questions, please contact

Zamayra Cantu at 888-733-4635 or **zcantu@redimd.com**