

VIII. ACCIDENT PACKET FORMS

ACCIDENT PACKET FORMS

The following pages contain examples of forms and notices, along with accompanying instructions to be used by employees, Supervisors, and the Claims Coordinator for reporting on-the-job injuries. The forms are straightforward and should be completed with little difficulty. Please contact the University Claims Coordinator for any needed assistance or explanation.

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS (TWCC-1S)

REQUIRED:

Form TWCC 1S must be completed by the supervisor and submitted to the Environmental Health & Risk Management. It will be processed and forwarded to the State Office of Risk Management for any injury that has more than one day of lost time, is an occupational disease with or without lost time or medical expenditures, resulted in the death of an employee, or results in expenditures for medical treatment or service.

FILING DEADLINE:

The form must be received at the State Office of Risk Management in Austin no later than the fifth calendar day after the injured employee's supervisor is first notified of the injury.

COMPLETED BY:

The injured employee's immediate supervisor is responsible for completing the form.

INSTRUCTIONS/NOTES:

- 1. Environmental Health and Risk Management prefers that the forms be typed. However, supervisors who have attended the *Compensation Responsibilities* class may substitute a handwritten Simplified TWCC-1S form.**
- 2. Ignore the "return of address" in the upper left hand corner of the form and send the completed form to the Claims Coordinator by fax (713/743-8035) and mail the originals to EHRM Mail Code 1005.**

Most items are self-explanatory. The following items require more attention:

- Item 2: This information is used by the Workers' Compensation Commission for non-discriminatory statistical use.
- Item 4: If no home phone, please give a phone number where the employee can be reached.
- Item 13: This is the name of the treating doctor if one is seen. If a doctor is not seen write NONE.
- Item 17: This should be the first full day of lost time from work. If the employee did not lose time, write NONE.
- Item 18: List the nature of the injury. Examples include: burn, cut or sprain.
- Item 19: List specific body part, e.g., chin, right leg, upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail. Use additional sheet of paper if necessary.
- Item 24: This should state the specific substance or exposure that directly inflicted the injury, such as a tool, chemical or machine.
- Item 28: This is the employee's immediate supervisor.
- Item 29: This is the date the employee reported the injury to the employer.
- Item 51: **Do not complete this line.** This must be the signature and title of the Claims Coordinator.
- Item 52: Enter the number of sick leave hours credited to the employee as of the date of injury.

DISTRIBUTION:

Return original to: Claims Coordinator, EHRM 1005 within 24 hours after receipt.
Retain copy for departmental file.

**EMPLOYEE'S ELECTION REGARDING
UTILIZATION OF SICK LEAVE (SORM-80)**

REQUIRED:

When an employee elects to utilize sick leave in lieu of receiving workers' compensation benefits.

FILING DEADLINE:

The form must be received by SORM no later than the fifth calendar day after the first day of lost time has occurred. **If this form is not signed and submitted on time then the employee will be automatically assigned Election 2 - to not use any accrued leave time.**

COMPLETED BY:

The employee makes the election, signs and dates the form. **Note, once the choice is made and given to the Claims Coordinator, it cannot be changed.**

INSTRUCTIONS:

See Attached Instruction Sheet

EHRM Note: If an employee plans to be off work for more than three (3) day then the department must get with the employee to file for the Family Medical Leave Act, the Human Resources Benefits Section should be contacted for complete details.

DISTRIBUTION:

Return original to: Claims Coordinator, EHRM 1005 within 24 hours after receipt.
Retain copy for departmental file.

**WITNESS STATEMENT
(SORM-74)**

REQUIRED:

Immediately after receiving notice of any injury, the supervisor should determine the names, addresses and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to the Environmental Health & Risk Management.

FILING DEADLINE:

The form(s) should be completed and returned with the “Employers’ First Report of Injury” within 24 hours to EHRM if possible. The form(s) must be received SORM no later than the fifth calendar day after the first notice of injury is reported to the agency.

COMPLETED BY:

The person giving the statement, with the assistance of the supervisor.

INSTRUCTIONS:

1. Except for the witness’s signature, the witness statement should be typewritten, if possible. If it must be handwritten, **YOU MUST PRINT**.
2. Be sure to fill in the claim number, if known.
3. The witness may have actually seen the accident, or may have acquired knowledge about the accident from some other source. The witness’s information may relate to how the accident occurred, or to something else that is relevant. Check the first or second box and fill in the blanks following those boxes, as is appropriate. Be specific and complete. Sometimes a person is listed as a witness who, when asked, claims to know nothing about the accident. In such a case, the third box should be checked.

DISTRIBUTION:

Return original to: Claims Coordinator, EHRM 1005. Retain copy for departmental file.

**AUTHORIZATION FOR RELEASE OF INFORMATION
(SORM-16)**

REQUIRED:

Immediately after sustaining a work-related injury, the injured employee should fill out this release form so that SORM can obtain copies of relevant medical documents from providers, which will assist in the handling of the claim.

FILING DEADLINE:

This form should be completed and returned with the “Employer’s First Report of Injury” within 24 hours to EHRM if possible. The form(s) must be submitted no later than one week after the first notice of injury is received from the employee.

COMPLETED BY:

The employee must complete this form. **The form must be signed and dated.**

INSTRUCTIONS:

1. The employee must clearly print his/her name on the patient line.
2. The employee must clearly print his/her name on the second line.
3. The employee must date and sign the form.

DISTRIBUTION:

Return original to: Claims Coordinator, EHRM 1005 within 24 hours after receipt.
Retain copy for departmental file.