MEMO

To: Injured Employee

From: Cheryl Joswiak
Workers' Comp Coordinator

Re: Workers' Comp

I have enclosed the First Report of Injury form to be filled out at the time of injury. Please fill out the form and return to me at Central Office **within 3 days**. I have also enclosed a copy of the Injured Worker Rights and Responsibilities and the Workers' Compensation Authorization to be taken with you to the doctor or hospital. You will also find the First Fill Information which will be needed to fill presriptions. It is your responsibility to go to a doctor that accepts workers' compensation claims.

If you have questions call me at 277-3700, ext. 2108.

WORKERS' COMPENSATION AUTHORIZATION

Employer's Name: Brenham Independent School District

Employer Contact: Cheryl Joswiak
(979) 277-3700 ext. 2108
(979) 277-3711 fax

Employee's Name: _____

Date of Injury: _____

Bill to: TRISTAR Risk Management
P. O. Box 2805
Clinton, IA 52733-2805
888-285-6708 Ext. 2832

Authorized Signature: *Cheryl Joswiak*
Cheryl Joswiak, Workers' Comp Coordinator

Employee's Medical Records Release Authorization:

I hereby authorize the primary practitioner/facility or any other practitioner/facility to which I am referred to release any medical information and/or copies of my medical records with regard to the above-referenced alleged work-related injury/illness, as well as any prior medical information and/or copies of my medical records regarding any medical condition which may have contributed to the above-referenced alleged work-related injury/illness. A copy of this signed release shall be considered as valid as an original.

_____ _____
Patient (Employee) Signature Date

_____ _____
Witness Date

Send the specified copies to
Deep East Texas Self Insurance Fund
and the injured employee.

*Employers – Do not send this form to the Texas Department of Insurance, Division of Worker's Compensation unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language YES☐ NO☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American☐ Other☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
City State Zip Code

15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y)
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
Street or P.O. Box County
City State Zip Code
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name
29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -
31. Was employee hired or recruited in Texas? YES ☐ NO ☐
32. Length of Service in Current Position Months_____ Years _____
33. Length of Service in Occupation Months_____ Years _____
34. Employee Payroll Classification Code
35. Occupation of Injured Worker
36. Rate of Pay at this Job $ Hourly$ Weekly
37. Full Work Week is: Hours Days
38. Last Paycheck was: $ for Hours or Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☒

40. Name and Title of Person Completing Form
Cheryl Joswiak, Workers' Comp Coordinator
41. Name of Business
Brenham Independent School District
42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone
P. O. Box 1147 (979) 277-3700
City State Zip Code
Brenham TX 77833
43. Business Location (If different from mailing address)
Number and Street
711 Mansfield Street
City State Zip Code
Brenham TX 77833
44. Federal Tax Identification Number
1-74-6000401-7
45. Primary North American Industry Classification System Code:(6 digit) 61111
46. Specific NAICS Code (6 digit) 61111
47. Texas Comptroller Taxpayer No.
99-991240-0
48. Workers' Compensation Insurance Company
Deep East Texas Self Insurance Fund
49. Policy Number
010189
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☒ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Cheryl Joswiak, Workers' Comp Coordinator Date _____

First Fill Information

Deep East Texas Self Insurance Fund
Serving Texas since 1974

CYPRESS CARE
A **Healthcare Solutions** Company

Dear Injured Worker,

Cypress Care has been selected by **Deep East Texas Self Insurance Fund** to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply **fill in the form below** and present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have no out-of-pocket expenses when you fill your first prescription.

For your convenience, Cypress Care has an extensive network of retail pharmacies including major chain drug stores.

For pharmacy locations, you may call our toll-free number or visit our website at **www.cypresscare.com** and use the pharmacy locator in the quick links section of the home page.

If you have any questions, or would like to learn about our convenient home delivery service, please call our customer service number: **888.220.2805**

Estimado Trabajador(a) Lesionado(a),

Cypress Care ha sido seleccionado por **Deep East Texas Self Insurance Fund** para asistirle en la obtención de medicamentos relacionados con su reclamo de compensación de trabajadores. Este formulario le permite completar las prescripciones escritas por el médico de sus empleados autorizados de compensación para los medicamentos relacionados con su lesión. Simplemente **llene el siguiente formulario** y preséntelo en la farmacia en el momento que su prescripción está lleno. Este formulario debe asegurarse de que usted no tendrá gastos de su propio bolsillo cuando surte su primera receta.

Para su comodidad, Cypress Care cuenta con una extensa red de farmacias al por menor. De la red de farmacias Cypress Care incluye las siguientes principales cadena de farmacias:

Para localidades de Farmacia adicional, también puede llamar a nuestro número gratuito o visite nuestro sitio web en **www.cypresscare.com** y usar el localizador de farmacias en la sección de enlaces rápidos de la página de inicio.

Si usted tiene alguna pregunta, o le gustaría aprender acerca de nuestro conveniente servicio al domicilio, llame a nuestro número gratuito de servicio al cliente: **888.220.2805**

First Fill Form: Complete and take to your pharmacy

Bin #: **010876** Group Number: **DEEPEASTTEXASFF**

Member ID:		Last 4 digits of SSN + date of injury; No spaces (i.e. 9999050206)
Member Name:		Injured worker's first & last name
Employer Name:	Brenham I.S.D.	
Date of Injury:		

Pharmacy Help Desk: **888.220.2805**

PLEASE NOTE: This form allows you to fill your initial prescriptions with a cost maximum of $150 per prescription and no more than a 10-day supply per prescription. Once your claim has been reviewed, you will be sent a new card in the mail. If you do not receive the pharmacy card, please call us at 888.220.2805.

Issuance of this letter does not constitute acceptance of your claim.

Injured Worker Rights and Responsibilities

Injured worker rights

- **An injured worker may have the right to receive benefits.**

  An injured worker may receive benefits regardless of who caused or helped cause the injury. An injured worker may not receive benefits if:

  - the injury occurred while the worker was intoxicated;
  - the worker injured himself or herself intentionally or while unlawfully attempting to injure someone else;
  - the worker was injured by another person for personal reasons;
  - the worker was injured while voluntarily participating in an off-work activity;
  - the worker was injured by an act of God; or
  - the injury occurred during horseplay.

- **An injured worker has the right to receive the medical care reasonable and necessary to treat a work-related injury or illness without any specific time limit.**

- **An injured worker has the right to the initial choice of doctor.**

  An injured worker may not change doctors except with the approval of the Commission. An injured worker does not need to get approval to go to a different doctor for emergency treatment.

- **An injured worker has the right to hire an attorney to help the worker get benefits or to help resolve disputes.**

- **An injured worker has the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding, from a Commission ombudsman free of charge.**

  Injured workers may request assistance by calling the field office handling their claims, or by calling 1-800-252-7031.

  An injured worker has the right to receive information and assistance regarding the worker's claim. Commission staff will explain the worker's rights and responsibilities under the Texas Workers' Compensation Act. Additionally, an injured worker has the right to be assisted by a Commission ombudsman in informal dispute resolution and in administrative proceedings if the worker is not represented. However, an ombudsman cannot serve as a legal representative or attorney.

- **An injured worker has the right to confidentiality.**

  Only people who need to know — such as the injured worker's doctor, employer, or employer's insurance carrier — may see information in the Commission's files. A prospective employer may get limited information from the Commission about an injured worker's claims, however.

Injured worker responsibilities

- **An injured worker has the responsibility to tell his or her employer about a work-related injury or illness.**

  An injured worker must tell his or her employer within 30 days of the date of the injury, or within 30 days of the date the worker first knew the illness might be work-related. The injured worker, or someone helping the worker, may either talk with or write the employer or any supervisor at the worker's place of employment.

  If an injured worker does not tell the employer within 30 days, the worker could lose the right to get benefits.

- **An injured worker has the responsibility to fill out a claim form and send it to the Commission.**

  An injured worker must send a completed claim form, called a TWCC-41, to the Commission within one year of the date the worker was injured, or within one year of the date the worker first knew the illness might be work-related. The completed claim form must be sent to the Commission even if the worker is already getting benefits.

  If an injured worker does not send the form within one year, the worker could lose the right to get benefits. Copies of the claim form may be obtained by calling any field office, or by calling 1-800-252-7031.

- **An injured worker has the responsibility to tell the Commission and the insurance carrier any time the worker's income changes.**

  An injured worker who is *not* getting benefits and who has changed employers since the injury must tell the Commission if the injury causes the worker to miss work or lose income. Call 1-800-252-7031.

  An injured worker who is getting benefits and who has changed employers since the injury must tell the Commission and the insurance carrier paying benefits if the worker's income changes. The injured worker must tell the Commission and the insurance carrier regardless of whether income went up or down.

  An injured worker who has stopped working since the injury must tell the Commission and the insurance carrier if the worker starts working again or has a job offer.

- **An injured worker has the responsibility to tell the doctors how the worker was injured and if the worker believes the injury may be work-related.**

  If possible, an injured worker should tell the doctor before the doctor provides treatment.

- **An injured worker has the responsibility to tell the Commission and the insurance carrier how to contact him or her.**

An injured worker should contact the Commission and the insurance carrier if the worker's home address, work address, or phone number changes, so the Commission and the insurance carrier will be able to contact the worker when necessary.