

**RISK MANAGEMENT DEPARTMENT
IRVING INDEPENDENT SCHOOL DISTRICT
P.O. BOX 152637
IRVING, TX 75015**

EMPLOYEE FIRST REPORT OF INJURY/ILLNESS

Instructions: To be completed by the supervisor of the injured employee. **ALL QUESTIONS MUST BE ANSWERED AND THIS FORM SIGNED BY BOTH THE EMPLOYEE AND HIS/HER SUPERVISOR.** Fax a copy of this completed form to 972-215-5239/Risk Management Department and supervisor is to retain a copy for their records.

PLEASE PRINT ON ALL LINES, EXCEPT SIGNATURES

1. Name of the injured _____
(First name) (M.I.) (Last Name) (SS#--Last Four Digits only)
2. Date of Birth _____ IISD Employee # _____
3. Address _____
(Number, Street, Apt. #) (City, State, Zip Code)
4. Telephone number _____
(Home) (Friend or Relative #)
5. Does employee speak English? _____ Yes _____ No
If "no", specify language _____
6. Race: _____ White _____ Black Ethnicity: _____ Hispanic _____ Other
_____ Asian _____ American Indian
7. Marital Status: _____ Married _____ Widowed _____ Divorced _____ Separated _____ Single
8. Number of Dependent Children _____ Spouse's Name _____
9. What is your job title? _____
Home Campus/Department _____
10. How long have you worked for Irving ISD? _____
11. **Date of Inj/Ill** _____ **Day of the Week** _____ **Time of Inj/Ill** _____ **a.m. p.m.**
12. School and location where incident occurred: _____
Was employee paid for this day? _____
13. Name of your Principal, Supervisor, or Lead person: _____
When did he/she first know of your injury/illness? _____
State the cause of injury/illness (machine, tool, wet surface, etc.) _____
14. Describe below FULLY how the incident occurred and state what the employee was doing when injured or ill. Describa completamente como ocurrio el accidente y diga lo que estaba hacienda el empleado cuando se lesiono/enfermedad.

(PLEASE BE SPECIFIC TO ANSWER ITEM 15. Example: upper, mid, or lower back; left or right hand; specific finger right or left –thumb, index, middle, ring, pinky, etc.)

15. Part(s) of the body injured: _____
Partes del cuerpo lesionadas

Describe the injury or illness: _____

Describe la lesion o enfermedad: _____

16. Has the employee sought medical care for this injury/illness? _____

17. Date a doctor first said employee was unable to work? _____

18. Name of the doctor treating this injury/illness: _____

Nombre del doctor dando tratamiento a esta lesion/enfermedad

Doctor's mailing address: _____

Direccion por correo del Doctor

Telephone #: _____

de Telefono

(**Employees have the right to the first choice of doctor that will treat under workers compensation. You may not change doctors without the approval of the Texas Department of Insurance (TDI)-Workers' Compensation Division) (Los empleados tienen el derecho de escoger su primer doctor. No se puede cambiar de doctor sin la aprobacion de la Comision de Compensacion de Texas de los Trabajadores.)

19. Witness to the injury/illness: _____ IISD Employee # _____

Witness' phone# (if not an Irving ISD employee): _____

20. The injured/ill employee must choose one of the following options by placing a check in the space provided. **Failure to choose either option will result in option "A" ONLY being chosen by default.**

“In the event that I miss work as a result of a job-related injury or illness, I understand that I will not be eligible for Workers’ Compensation weekly income benefits until my absence exceeds seven work days. I choose the following option(s):

_____ **Option A:** I choose to use all available sick and personal leave days. During the first seven calendar days (5 work days plus a weekend) 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. At the same time I will use **unpaid** Family and Medical Leave (if I am an eligible employee).

_____ **IN ADDITION TO OPTION A, I also choose to use all vacation, floating holiday, comp time, and exemplary attendance days as well.**

_____ **Option B:** I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Irving ISD 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 position. At the same time I will use **unpaid** Family and Medical Leave (if I am an eligible employee).

(Signature of Employee)

(Date)

(Signature of Supervisor)

(Date)

What do I do if I get injured at work???

1. All on-the-job injuries/illnesses must be reported to your supervisor immediately – even if you don't think you will need medical treatment or need to be off work.
2. Complete an “Employee First Report of Injury/Illness” form. Have your department head (or designee) sign it. Send the original to the Risk Management Department by Interoffice Mail.
3. Fax all “Employee First Report of Injury/Illness” forms to Judyann Robinson/Risk Manager.

Fax #: 972-215-5239

4. If/when you seek medical treatment: Make certain your doctor is aware that you are needing to be treated under Workers' Compensation when you make your appointment. You may treat with any doctor of your choice – **however, doctors may choose not to treat patients under Workers' Compensation.**
5. If your doctor will not treat you under Workers' Compensation, you will need to select a dr. who will. Physicians who will treat injuries under W/C are listed on a flyer available with the “First Report of Injury/Illness” form.

¿Qué hago si me lastimo en el trabajo?

1. Todas las lesiones/enfermedades que suceden en el trabajo deben ser reportadas a su supervisor inmediatamente – aun si usted no piensa necesitar atención medica o faltar al trabajo.
2. Llene un formulario “Employee First Report of Injury/Illness”. Obtenga la firma del jefe de departamento (ó persona designada). Mande el original al Departamento de Administración de Riesgos via correo del Distrito.
3. Envie por fax todos los formularios “Employee First Report of Injury/Illness” a Judyann Robinson/Administradora de Riesgos.

de Fax: 972-215-5239

4. Cuando/si usted busca atención medica: Asegúrese que su doctor este enterado que usted esta necesitando tratamiento bajo Compensación de Trabajadores cuando haga su cita. Usted puede ser tratado por cualquier doctor que usted elija – **sin embargo, doctores pueden elegir el no tratar a pacientes bajo Compensación de Trabajadores.**
5. Si su doctor no le puede dar tratamiento bajo Compensación de Trabajadores, usted tendrá que seleccionar un doctor que si pueda. Hay una lista adjunta al formulario “Employee First Report of Injury/Illness” de doctores que si dan tratamiento bajo Compensación de Trabajadores.