Workman's Compensation Manual

Texas A&M Forest Service (TAMFS)

April 2023

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I. Preface

Purpose

Filing a workers' compensation claim requires both ***employee*** and ***supervisor*** to provide adequate information and details in a timely manner. The purpose of this manual is to provide guidance when filing a workers' compensation claim for an intrastate fire mutual aid system team member or a regional incident management team member.

Deployments:

An intrastate fire mutual aid system team member or a regional incident management team member, as defined by Section 88.126, Education Code, who sustains an injury or illness as a result of a deployment or during any Texas Division of Emergency Management (TDEM) sponsored or sanctioned training will be included in the coverage provided under *Chapter 501 of the Texas Labor Code* in the same manner as an employee, as defined by *Section 501.001.* Services with Texas A&M Forest Service (TAMFS) by an activated member who is a state employee are considered to be in the course and scope of the employee's regular employment with the State.

Key Personnel

TAMFS Agency Representative

- Serves as the liaison between the response member and the TAMFS Safety Officer during the initial submission.
- Reviews required documentation for completion and submits to TAMFS Safety Officer.

TAMFS Safety Officer

- Submits paperwork to the State Office of Risk Management (SORM) and is the point of contact to obtain any pertinent information regarding the claim.
- Maintains the workman's compensation manual to ensure TAMFS remains in compliance with system policies and procedures.

II. Filing a Workman's Comp Claim

I have been injured on a deployment/training and want to file a state claim.

Should I report it?

- *YES, report ALL injuries or medical issues developed during a deployment or training, no matter how minor*. All members of an All Hazard IMT or TIFMAS response are required to immediately report any injury to their field supervisor and TAMFS Agency Representative during a deployment.
- *Good rule of thumb… D*id you have this *before* the training/deployment? If ***NO,*** then report it.
- Given the conditions that responders are exposed to, issues may not appear until a later date. No matter how minor the injury may seem or if the member refuses to seek medical attention at the time of the injury, the First Report of Injury (and applicable witness statement) are required to be submitted within the requested time frame.
- See attached check list and forms that follow.

Failure to complete the First Report of Injury at the date/time of injury may result in removal of the injured member from the incident or training event and may further result in disciplinary actions.

Who should I notify?

- Report to your supervisor and TAMFS Agency Representative in the field as they have the appropriate paperwork to complete.
- Response members are encouraged to notify their participating agency. However, an official with Texas A&M Forest Service can contact their agency as a courtesy.
- In the event of death of a response member, the TAMFS Agency Representative should be notified immediately, they will contact the TAMFS FRP Associate Director, who will then contact the participating Agency Chief.

What's next?

- Supervisors will assist in completing the required paperwork and notify the TAMFS Agency Representative & TAMFS Safety Officer

  Contact Information:
  - TAMFS Agency Representative
    - 254-220-5138 (1st Call)
    - 512-913-3964 (2nd Call)
    - 936-202-0688 (3rd Call)
    - agencyrep@TAMFS.tamu.edu
  - Safety Officer
    - 979-458-6697
    - safety@TAMFS.tamu.edu

- Required paperwork is due to the individuals listed above within 12 hours of the injury:
  - ***Employers First Report of Injury DWC-1***- First Report of Injury
    - Any supporting hospital documentation may be provided in addition to the DWC-1 to assist the State Office of Risk Management in processing the claim.
  - ***Texas Workers' Compensation Work Status Report DWC-73***- Provided by the treating facility
  - ***Supplemental Witness Statement for First Report of Injury TAMFS-WC2*** - Supervisor collects and submits all Supplemental Witness Statements.
  - ***TAMFS Accident Investigation Report TAMFS WC-1 - Top section only is required to be submitted in the first 12 hours. The remainder is required within 10 days.***
- If the injury did not require medical attention, TAMFS Agency Representative will NOT submit to the TAMFS Safety Officer to process. The paperwork will be filed securely, and in the event medical attention is required at a later date, the paperwork will be submitted at that time to begin the workman's compensation process.

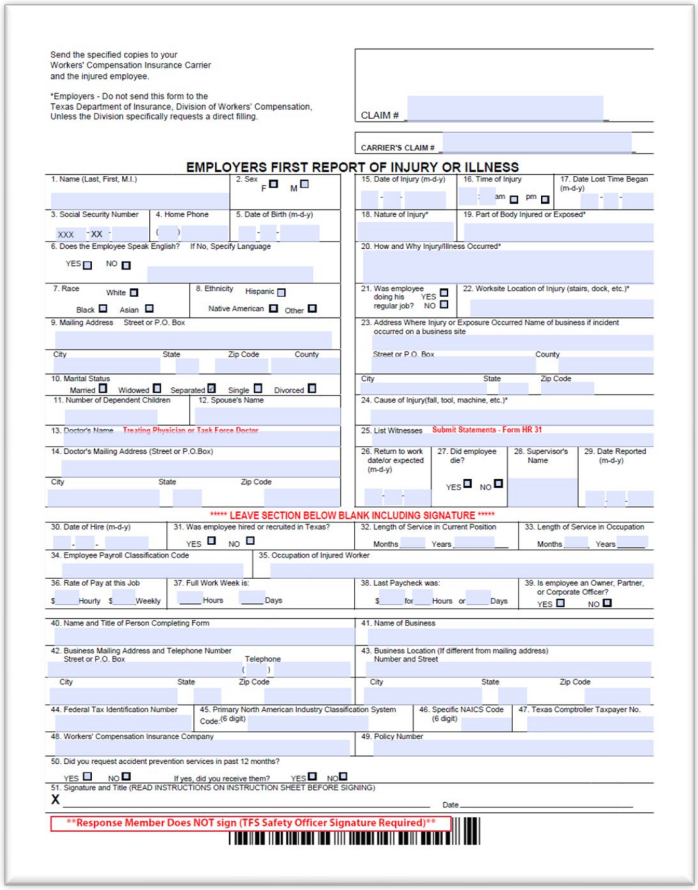
III. What Forms Do I Complete?

All required forms can be found at the following web address, ticc.tamu.edu/incident response.

First Report of Injury DWC-1

Submit to the TAMFS Safety Officer within 12 hours of the injury to allow adequate amount of time for final submission of the paperwork to System Office of Risk Management (SORM) which is due within 24hours.

- Complete top two sections only.
- All other info is to be completed by TAMFS Safety.
- Response Members do not sign the form.



Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' 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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number XXX-XX- | 4. Home Phone ( ) | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? YES NO If No, Specify Language | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | City State Zip Code County | 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

10. Marital Status Married Widowed Separated Single Divorced | 11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name Treating Physician or Task Force Doctor | 25. List Witnesses Submit Statements - Form HR 31

14. Doctor's Mailing Address (Street or P.O.Box) | City State Zip Code | 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)

***** LEAVE SECTION BELOW BLANK INCLUDING SIGNATURE *****

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 | 41. Name of Business

42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( ) | 43. Business Location (if different from mailing address) Number and Street

City State Zip Code | City State Zip Code

44. Federal Tax Identification Number | 45. Primary North American Industry Classification System Code (6 digit) | 46. Specific NAICS Code (6 digit) | 47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company | 49. Policy Number

50. Did you request accident prevention services in past 12 months? YES NO If yes, did you receive them? YES NO

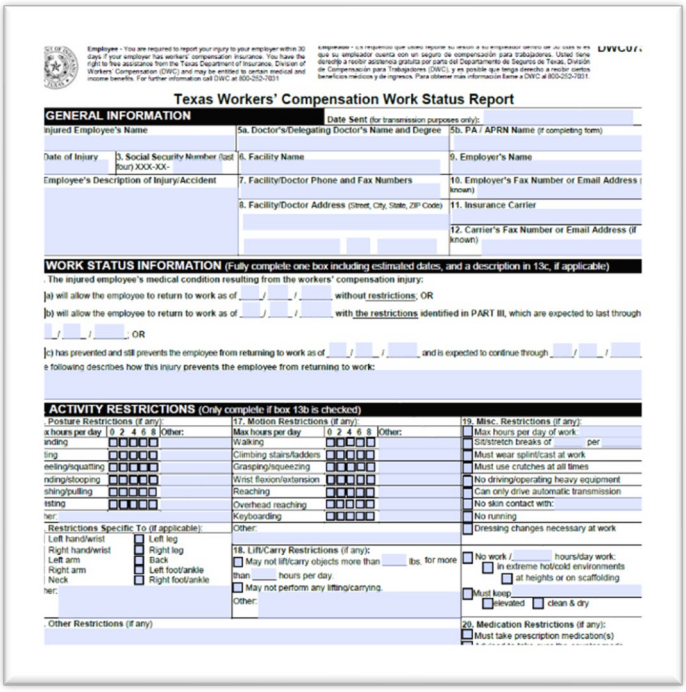
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X _____ Date _____

Response Member Does NOT sign (TFS Safety Officer Signature Required)

Work Status Report DWC-73

Provided by the treating facility and is a required form to be submitted at the same time of the DWC-1



Texas Workers' Compensation Work Status Report

GENERAL INFORMATION

Injured Employee's Name | 5a. Doctor's/Delegating Doctor's Name and Degree | 5b. PA / APRN Name (if completing form)

Date of Injury | 3. Social Security Number (last four) XXX-XX- | 6. Facility Name | 9. Employer's Name

Employee's Description of Injury/Accident | 7. Facility/Doctor Phone and Fax Numbers | 10. Employer's Fax Number or Email Address (if known)

8. Facility/Doctor Address (Street, City, State, ZIP Code) | 11. Insurance Carrier

12. Carrier's Fax Number or Email Address (if known)

WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if applicable)

The injured employee's medical condition resulting from the workers' compensation injury:

(a) will allow the employee to return to work as of ___/___/___ without restrictions; OR

(b) will allow the employee to return to work as of ___/___/___ with the restrictions identified in PART III, which are expected to last through ___/___/___; OR

(c) has prevented and still prevents the employee from returning to work as of ___/___/___, and is expected to continue through ___/___/___

e following describes how this injury prevents the employee from returning to work:

ACTIVITY RESTRICTIONS (Only complete if box 13b is checked)

Posture Restrictions (if any):
x hours per day | 0 2 4 6 8 | Other:
nding
ling
eeling/squatting
nding/stooping
shing/pulling
isting
ner:

Restrictions Specific To (if applicable):
Left hand/wrist, Right hand/wrist, Left arm, Right arm, Neck, Left leg, Right leg, Back, Left foot/ankle, Right foot/ankle
ner:

Other Restrictions (if any)

17. Motion Restrictions (if any):
Max hours per day | 0 2 4 6 8 | Other:
Walking
Climbing stairs/ladders
Grasping/squeezing
Wrist flexion/extension
Reaching
Overhead reaching
Keyboarding
Other:

18. Lift/Carry Restrictions (if any):
☐ May not lift/carry objects more than ___ lbs. for more than ___ hours per day
☐ May not perform any lifting/carrying.
Other:

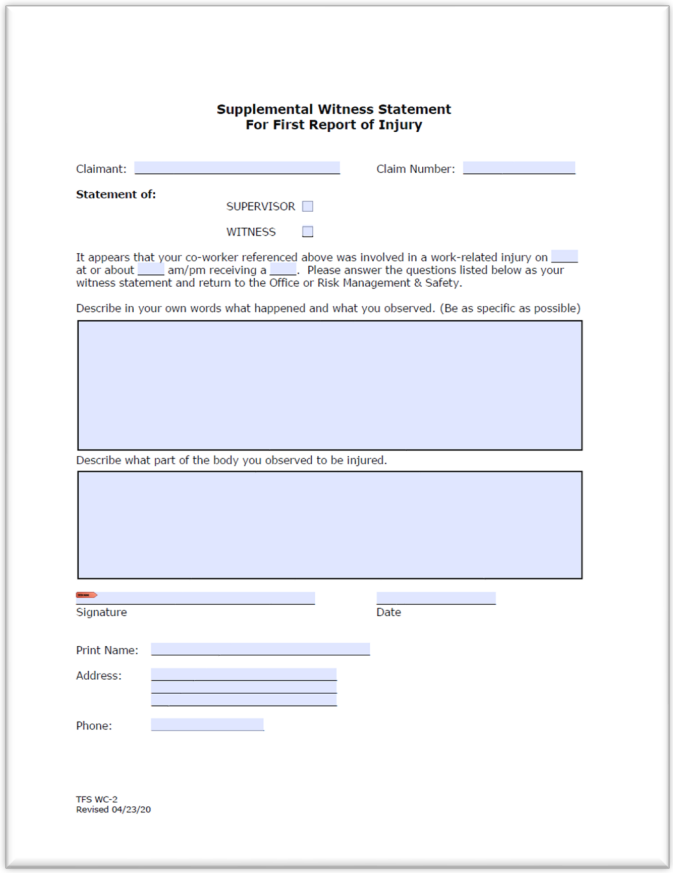
19. Misc. Restrictions (if any):
☐ Max hours per day of work
☐ Sit/stretch breaks of ___ per
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No skin contact with:
☐ No running
☐ Dressing changes necessary at work
☐ No work / ___ hours/day work:
☐ In extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep ___ ☐ elevated ☐ clean & dry

20. Medication Restrictions (if any):
☐ Must take prescription medication(s)

TAMFS-WC2

Supervisor collects and submits Supplemental Witness Statement

- The witness should include details of what they saw, they are encouraged to only provide facts rather than conclusions or hear say
- If there are multiple witnesses to the event, please have each one complete the TAMFS-WC2



Supplemental Witness Statement
For First Report of Injury

Claimant: _____ Claim Number: _____

Statement of:

SUPERVISOR ☐

WITNESS ☐

It appears that your co-worker referenced above was involved in a work-related injury on ____ at or about ____ am/pm receiving a ____. Please answer the questions listed below as your witness statement and return to the Office or Risk Management & Safety.

Describe in your own words what happened and what you observed. (Be as specific as possible)

Describe what part of the body you observed to be injured.

Signature _____ Date _____

Print Name: _____

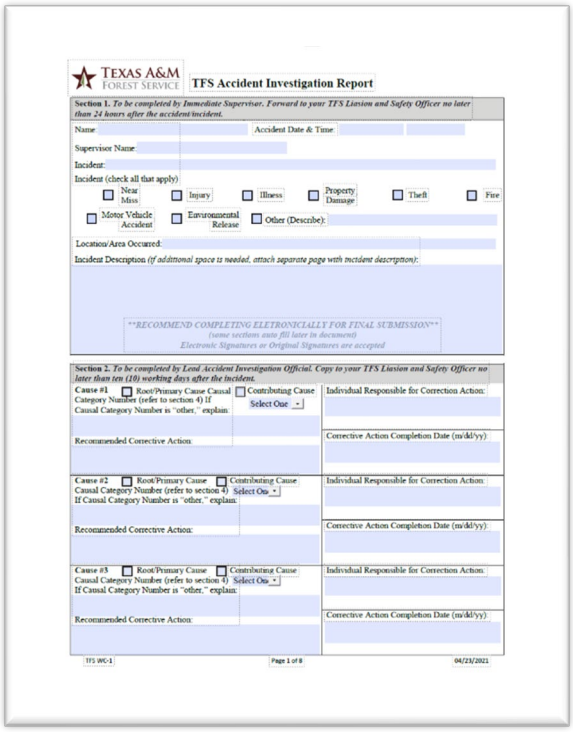
Address: _____

Phone: _____

TFS WC-2
Revised 04/23/20

TAMFS Accident Investigation Report

TAMFS Agency Representative completes top section only and submits along with ***DWC-1*** and ***DWC-73.*** The Remaining Accident Investigation Report is due to the TAMFS Safety Officer within 10 days after the injury for final submission



TEXAS A&M FOREST SERVICE

TFS Accident Investigation Report

Section 1. *To be completed by Immediate Supervisor. Forward to your TFS Liaison and Safety Officer no later than 24 hours after the accident/incident.*

Name: Accident Date & Time:

Supervisor Name:

Incident:

Incident (check all that apply):

☐ Near Miss ☐ Injury ☐ Illness ☐ Property Damage ☐ Theft ☐ Fire

☐ Motor Vehicle Accident ☐ Environmental Release ☐ Other (Describe):

Location/Area Occurred:

Incident Description *(If additional space is needed, attach separate page with incident description):*

RECOMMEND COMPLETING ELETRONICIALLY FOR FINAL SUBMISSION
(some sections auto fill later in document)
Electronic Signatures or Original Signatures are accepted

Section 2. *To be completed by Lead Accident Investigation Official. Copy to your TFS Liaison and Safety Officer no later than ten (10) working days after the incident.*

Cause #1 ☐ Root/Primary Cause ☐ Contributing Cause
Causal Category Number (refer to section 4) If Causal Category Number is "other," explain: Select One
Individual Responsible for Correction Action:
Recommended Corrective Action:
Corrective Action Completion Date (m/dd/yy):

Cause #2 ☐ Root/Primary Cause ☐ Contributing Cause
Causal Category Number (refer to section 4) Select One
If Causal Category Number is "other," explain:
Individual Responsible for Correction Action:
Recommended Corrective Action:
Corrective Action Completion Date (m/dd/yy):

Cause #3 ☐ Root/Primary Cause ☐ Contributing Cause
Causal Category Number (refer to section 4) Select One
If Causal Category Number is "other," explain:
Individual Responsible for Correction Action:
Recommended Corrective Action:
Corrective Action Completion Date (m/dd/yy):

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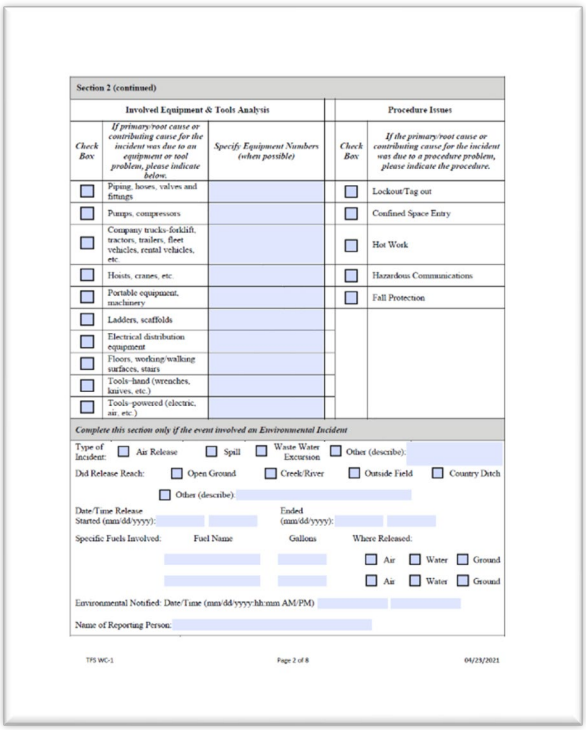


Section 2 (continued)

Involved Equipment & Tools Analysis			Procedure Issues	
Check Box	*If primary/root cause or contributing cause for the incident was due to an equipment or tool problem, please indicate below.*	*Specify Equipment Numbers (when possible)*	*Check Box*	*If the primary/root cause or contributing cause for the incident was due to a procedure problem, please indicate the procedure.*
☐	Piping, hoses, valves and fittings		☐	Lockout/Tag out
☐	Pumps, compressors		☐	Confined Space Entry
☐	Company trucks-forklift, tractors, trailers, fleet vehicles, rental vehicles, etc.		☐	Hot Work
☐	Hoists, cranes, etc.		☐	Hazardous Communications
☐	Portable equipment, machinery		☐	Fall Protection
☐	Ladders, scaffolds			
☐	Electrical distribution equipment			
☐	Floors, working/walking surfaces, stairs			
☐	Tools-hand (wrenches, knives, etc.)			
☐	Tools-powered (electric, air, etc.)			

Complete this section only if the event involved an Environmental Incident

Type of Incident: ☐ Air Release ☐ Spill ☐ Waste Water Excursion ☐ Other (describe):

Did Release Reach: ☐ Open Ground ☐ Creek/River ☐ Outside Field ☐ Country Ditch ☐ Other (describe):

Date/Time Release Started (mm/dd/yyyy): Ended (mm/dd/yyyy):

Specific Fuels Involved: Fuel Name Gallons Where Released:

☐ Air ☐ Water ☐ Ground

☐ Air ☐ Water ☐ Ground

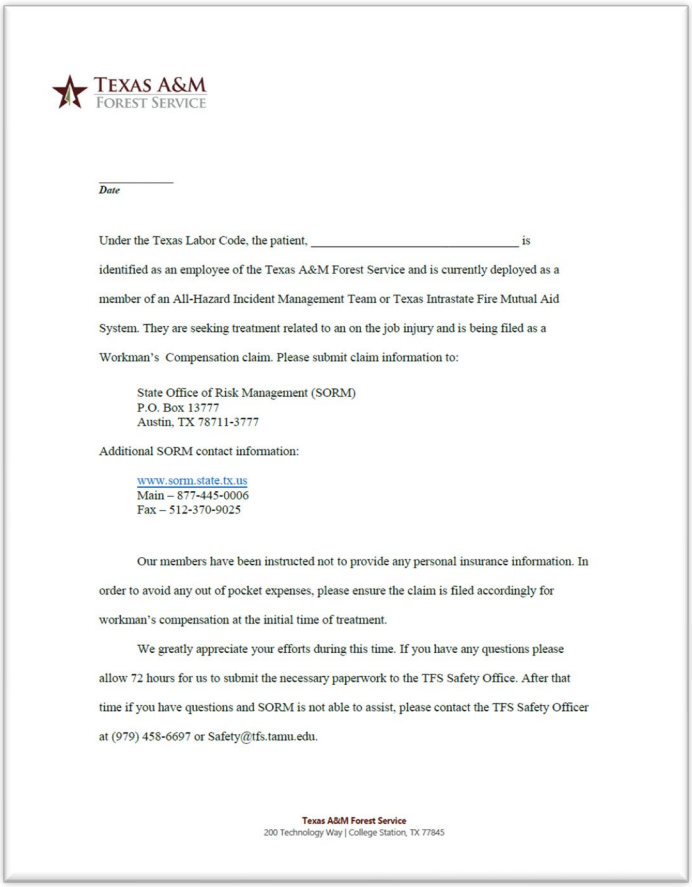
Environmental Notified: Date/Time (mm/dd/yyyy/hh:mm AM/PM)

Name of Reporting Person:

TFS WC-1 Page 2 of 8 04/23/2021

IV. What do I present to the hospital and pharmacy?

TAMFS Workman's Compensation Letter that explains this injury is being filed as a work-related injury.



TEXAS A&M FOREST SERVICE

_____
Date

Under the Texas Labor Code, the patient, _____ is identified as an employee of the Texas A&M Forest Service and is currently deployed as a member of an All-Hazard Incident Management Team or Texas Intrastate Fire Mutual Aid System. They are seeking treatment related to an on the job injury and is being filed as a Workman's Compensation claim. Please submit claim information to:

State Office of Risk Management (SORM)
P.O. Box 13777
Austin, TX 78711-3777

Additional SORM contact information:

www.sorm.state.tx.us
Main – 877-445-0006
Fax – 512-370-9025

Our members have been instructed not to provide any personal insurance information. In order to avoid any out of pocket expenses, please ensure the claim is filed accordingly for workman's compensation at the initial time of treatment.

We greatly appreciate your efforts during this time. If you have any questions please allow 72 hours for us to submit the necessary paperwork to the TFS Safety Office. After that time if you have questions and SORM is not able to assist, please contact the TFS Safety Officer at (979) 458-6697 or Safety@tfs.tamu.edu.

Texas A&M Forest Service
200 Technology Way | College Station, TX 77845

NOTE:

ALL Emergency Rooms/Occupational Medical Facilities accept workman's comp, but some general practice/family doctors do not.

When following up with your primary care doctor after the initial treatment, confirm that they accept workman's comp claims. If they do not, you will need to find another doctor if you choose to pursue the claim.

Paying for Treatment

- There should be **NO** out of pocket expenses for the response member if the claim is set up correctly at the initial time of medical treatment
- The **TAMFS *Workman's Compensation Letter*** should be given to the pharmacy if prescriptions are needed

Reminder – Response Members should ***NOT*** give personal insurance information to the treatment facility or a pharmacy

- After the claim has been submitted, the response members will be contacted by the TAMFS Safety Officer, who will provide you with a case worker information.

V. What happens after my paperwork is sent to the TAMFS Safety Office?

- TAMFS – Safety forwards the claim to the State Office of Risk Management to be processed
- When an adjuster is assigned, they will contact TAMFS-Safety to verify the information provided and investigate the claim. It is imperative to include all the information requested to avoid any delays in processing your claim
- The adjuster will call TAMFS-Safety periodically to obtain updates or to verify that the employee has returned to work. It is the injured Response Member's responsibility to contact TAMFS-Safety if there are any changes in their status
- For the injured Response Member to be eligible for any future trainings or deployments following their work-related injury, they are requested to forward the release signed off by the treating physician to the TAMFS Safety Officer. This is typically an updated DWC-73 form.
- If a response member receives a bill related to the injury, they will need to contact their adjuster to answer any questions.

TAMFS-ALL HAZARD & TIFMAS

Workman's Comp Check List

All paperwork is due to the TAMFS Agency Representative within 12 hours of the injury.

TAMFS Agency Representative

- 254-220-5138 (1st Call)
- 512-913-3964 (2nd Call)
- 936-202-0688 (3rd Call)
- Email: **agencyrep@TAMFS.tamu.edu**

TAMFS Environmental Health & Safety Officer

- Phone: 979-458 6697
- Email: **safety@TAMFS.tamu.edu**

☐ ***(DWC-1) Employers First Report of Injury***

- Complete only section 1 and 2
- *Do not sign*, TAMFS Safety is required to sign off
- At the time of treatment or receiving prescriptions, provide Response Member letter identifying as a Workman's Comp related injury

☐ ***(DWC-73) Work Status Report***

- Provided by the treating facility (required to submit with DWC-1)

☐ ***(TAMFS WC-2) Supplemental Witness Statement***

- Supervisor collects info from any witnesses and submits along with DWC-1
- For multiple witnesses, each person completes a form

☐ ***(TAMFS WC-1) TAMFS Accident Investigation Report***

- TAMFS Agency Representative completes top section ONLY and submits along with DWC-1 and DWC-73 (remaining accident investigation is due to TAMFS Safety Officer 10 days following injury)