Workplace Illness and Injury Reporting

Policy number: 000183262
Effective date: January 2022
Next review date: January 2023
Reviewer: HR Manager

1. **Purpose**
   The following procedures, which are in accordance with applicable laws are provided to assist employees in reporting work-related injury or illness to ensure compliance with state regulations and university policy.

2. **Employees**

   2.1 Life Threatening Medical Emergencies - injuries or illnesses that need immediate medical care.

   A. If an employee is faced with a medical emergency, he/she or a coworker may call 911 for emergency medical treatment to dispatch; or

   B. Go to the closest emergency room;

   2.2 Non-life Threatening Injuries or Illnesses. The following procedure must be followed in case of work related injury or illness.

   A. Injured worker must report the workplace injury to his/her supervisor as soon as possible, within one business day; and

   B. Complete an Injury Report form or Wavier of Medical Treatment with the school nurse and submit form to the Human Resources department. An authorizer will need to fill out the "Authorization for Examination & Treatment" form. Injured employee will visit the *WorkWell Network:* **Texas MedClinic**

   List of Authorizers to send employees: Roselie Hewitt, Sandra Flores, Nurse Robin Wilhoit, Khalid Zakaria, Jeffrey Flores, Dr. Monica Villarreal, and Alice Martinez.

   C. Meet with Human Resources to review documents and file a claim for workers' compensation after returning from clinic.

3. **Supervisors**

   3.1 Perform accident investigation to determine root cause(s) associated with the injury or illness and take photos as required and report findings within 24 hours of accident/injury.

   3.2 Implement progressive disciplinary action, if root cause is determined to be the result of the employee's engagement in unsafe work practices for which the employee has been trained and such training is documented.

4. **Office of Human Resources**

   4.1 Report injury or illness to the Workers' Compensation insurance carrier.

   4.2 Provide notice to the employee's supervisor regarding the individual's status and/or restrictions, next appointment, and treatments as provided by physician.

   4.3 Provide notice to payroll to ensure employee is compensated for reasonable time spent at doctors and treatment appointments.

   4.4 Monitor records with the insurance carrier regarding employee status, treatment, restrictions, appointments, etc.

Texas MedClinic Contact Information:

- Maria Cuellar
- Mcuellar1@texasmedclinic.com
  (210) 349-5577 ext. 8521

Questions about this policy may be addressed to:
New Frontiers Public Schools - Office of Human Resources
901 NE Loop 410, Ste. 711, San Antonio TX 78209
210-519-3900

*** Authorization for Examination & Treatment form / Waiver of Medical Treatment form is attached*

REPORT OF EMPLOYEE ACCIDENT

Employee Name:	Employee Social Security Number:
Address:	Date of Birth:
Phone Number:	Title:
Male ☐ Female ☐	Work Location:
Date of Accident:	Time of Accident: AM / PM
Employee Required Medical Attention: ☐ YES ☐ NO	Lost time From Work: ☐ YES ☐ NO
First Full Day Out:	Date Returned to Work:
Employee Seen by: Date:________________ ☐ TexasMed Clinic ☐ Other ☐ N/A	If Other, Employee Seen Where:
Employee Statement (Please be specific):____ ____ ____ ____ ____ ____	
Employee Signature:	Date:
Nurse Statement/Assessment: ____ ____ ____ ____	
Supervisor Signature:	Date:

Texas MedClinic®

Urgent Care…For Life's Little Emergencies™

Urgent Care | Occupational Medicine

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www.texasmedclinic.com

Work-Related Injury Treatment Authorization

(This form is to be used as authorization to evaluate and treat an injured worker. If you only require drug testing services, please use Occupational Treatment Authorization.)

Employee Name: ____

Job Title: ______________________ **Social Security #:** __________________ **DOB:**______________

Date of Injury:________________________ **Claim #** (if applicable) **:**______________________

Company Name: ____ **Employer Profile ID #** ___________

Address: ____ **Dept/ Location:** _____________

Phone: ____________________________ **Email :** ______________________________________

Person Authorizing (Please Print): ______________________________________ **Title:** ____________

☐ **New Company Account with Texas MedClnic** ☐ **Existing Company Account with Texas MedClinic**

MEDICAL EVALUATION

Physician Evaluation Only

Physician Evaluation & Post Accident Testing

POST ACCIDENT DRUG & ALCOHOL TESTING

NON-DOT DRUG TESTING

5 Panel

10 Panel

Rapid 5 Panel *

Rapid 10 Panel *

Hair Drug Test

**Rapid Drug Testing is Non-DOT Only using Texas MedClinic lab. Same day negative results before 2 pm, Mon-Fri. Specimens requiring further testing can take 2-7 business days depending on results and date/time of collection.*

DOT DRUG TESTING

DOT Drug Test

DOT Testing Agency		DOT Testing Authority
FMCSA	FTA	DOT
FAA	PHMSA	HHS
FRA	USCG	NRC

BREATH ALCOHOL TESTING

Non-DOT

DOT

Chain of Custody Form

Electronic (Form Fox)

Employee will hand carry

Forms on file at clinic

Consortium/Third Party Administrator

DISA

Onsite Services

CMI

FleetScreen

HireRight

Other: ___________

BILLING INFORMATION

In order to treat your work-related injury, Texas MedClinic MUST obtain the billing information for either your employer or your employer's Workers Compensation insurance. State laws set forth by the Division of Workers Compensation prohibit medical providers from billing or accepting payment from the patient for the treatment of work-related injuries if the company has Workers Compensation Insurance. If we CANNOT determine if your employer has insurance for work-related injuries OR proper billing information for your employer, our providers will ensure that you are medically stable and then you MAY be referred to the emergency room for further evaluation and treatment.

Name of Workers Comp Insurance (if applicable) :

____

Billing Address:

____

Phone: **Fax:**

____

Email:

____

If you are a subscriber, are you in a Network? Yes No

Please indicate name of Network: ______________________________

Workers Comp Billing Contact:

Name:

____

Phone:

____

Fax:

____

Email:

____

Notes:

Office Use Only: ☐ TA completed by Employer ☐ TA completed by Clinic Staff Staff Name: ____________ Date: __________ Time: ____________

EMPLOYEE WAIVER OF MEDICAL TREATMENT

DATE: ____________________

EMPLOYEE NAME: ____

As of the date noted above, I am notifying my employer of an injury that occurred on

________________, 202__

- ❑ My supervisor did not receive notification of this incident.
- ❑ My supervisor did receive notification of this incident on _______, 202__

This injury, (briefly describe condition) __________________________________

____

occurred during the normal scope and duties of employment.

At this time, I have been requested by my employer to be medically evaluated by a *preferred medical provider within the managed care network*. **I decline to be medically evaluated for the above noted condition.**

I understand that by signing this document, any future claims regarding this injury will require a medical evaluation by a preferred medical provider within the managed care network or I may be responsible for any medical bills or lost wages. I also understand that should I seek treatment for this injury, I must first notify my supervisor and go to a provider in the managed care network.

SHOULD THE CONDITION BECOME LIFE THREATENING
SEEK APPROPRIATE EMERGENCY CARE IMMEDIATELY

EMPLOYEE STATEMENTS

By signing this form I acknowledge:

- I have not sought medical treatment for this injury
- I understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.
- I have read the above information and agree it is factual and true statement. I authorize any physician, hospital or healthcare provider to release and furnish any and all medical records or other information pertaining to the above listed condition.

____________________________	____________________________
Employee Signature	**Supervisor/Witness Signature**
____________________________	____________________________
Date	**Date**