Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel. This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the state agency that administers the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Also, more information is available on the Internet at: **www.oiec.state.tx.us <http://www.oiec.state.tx.us>.** You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division of Workers' Compensation is available on the Internet at: **<http://www.tdi.state.tx.us/wc/indexwc.html>.**

Your Rights in the Texas Workers' Compensation System:

1. You may have the right to receive benefits.

You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:

- You were intoxicated at the time of the injury;
- You injured yourself on purpose or while trying to injure someone else;
- You were injured by another person for personal reasons;
- You were injured by an act of God;
- Your injury occurred during horseplay; or
- Your injury occurred while voluntarily participating in an off-duty recreational, social, or athletic activity.

2. You have the right to receive medical care to treat your workplace injury or illness. There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.

3. Choosing a treating doctor:

- If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list.
- If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
- If you are employed by a political subdivision (e.g. city, county, school district), you must follow its rules for choosing a treating doctor.

It is important to follow all the rules in the workers' compensation system. If you do not follow these rules, you may be held responsible for payment of medical bills.

4. You have the right to hire an attorney at any time to help you with your claim.

5. You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.

Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.

6. You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.

An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of workers' compensation and provide free assistance to injured employees who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

7. You have the right for your claim information to be kept confidential.

In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an

employer that is considering hiring you may get limited information about your claim from the Division of Workers' Compensation.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.
You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.

2. You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).
If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. Your employer must give you a copy of the TDI network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at **<http://www.tdi.state.tx.us/consumer/complfrm.html#wc>**

3. If you worked for a political subdivision (e.g. city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment. Your employer should be able to provide you with the information you will need in order to determine which health care provider can treat you for your workplace injury.

4. You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.

5. You have the responsibility to send a completed claim form (DWC-41) to the Division of Workers' Compensation. You have one year to send the form after you were injured or first knew that your illness might be work related.
Send the completed DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation. Call 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

6. You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.

7. You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:

- **You stop working because of your injury;**
- **You start working; or**
- **You are offered a job.**

NOTICE OF INJURED EMPLOYEE RIGHTS AND RESPONSIBILITIES-SPANISH

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores

Como empleado lesionado en Texas, usted tiene derecho a recibir ayuda por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (OIEC, por sus siglas en inglés). Esta ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también proporcionan otros servicios del sistema de compensación para trabajadores por parte del Departamento de Seguros de Texas (TDI, por sus siglas en inglés.) TDI, es una agencia estatal que administra el sistema mediante la División de Compensación para Trabajadores.

Comuníquese con OIEC llamando gratis al teléfono 1-866-EZE-OIEC (1-866-393-6432.) Para información adicional, visite la siguiente página de Internet: www.oiec.state.tx.us.

Comuníquese con la División de Compensación para Trabajadores llamando gratis al teléfono 1-800-252-7031. Para información adicional, visite la siguiente página de Internet: www.tdi.state.tx.us/wc/indexwc.html.

Sus derechos dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted puede tener derecho a recibir beneficios.** Usted puede recibir beneficios sin importar quien causó su lesión con ciertas excepciones, tales como:
   - Si usted se encontraba intoxicado cuando ocurrió la lesión;
   - Si usted se lesionó intencionalmente o mientras estaba tratando de lastimar a otra persona;
   - Usted fue lastimado por otra persona por razones personales;
   - Usted fue lastimado por un acto de Dios;
   - Su lesión ocurrió cuando estaba jugando en su trabajo; o
   - Su lesión ocurrió mientras participaba voluntariamente en una actividad fuera del trabajo y después de horas laborables.

2. **Usted tiene derecho a recibir cuidado médico por su lesión o enfermedad relacionada con su trabajo. No existe ningún límite de tiempo para recibir este cuidado médico.**

3. **Usted tiene derecho a escoger su médico tratante. Si usted es parte de una red de servicios médicos de compensación para trabajadores, usted puede escoger su médico de la lista de médicos tratantes de la red de servicios médicos. Si usted no pertenece a una red de servicios médicos, usted debe entonces escoger un médico de la Lista Aprobada de Doctores de la División de Compensación para Trabajadores (DWC, por sus siglas en inglés).**
   Es muy importante que siga los reglamentos del Sistema de Compensación para Trabajadores para evitar que usted tenga que pagar cuentas médicas.

4. **Usted tiene derecho a contratar un abogado en cualquier momento para que le ayude con su reclamo.**

5. **Usted tiene derecho a recibir información y ayuda por parte de la Oficina de Asesoría Pública para el Empleado Lesionado sin costo alguno.**
   El personal de OIEC está disponible para contestar sus preguntas y explicarle sus derechos y responsabilidades llamando al teléfono 1-866-EZE-OIEC (1-866-393-6432).

6. **Usted tiene derecho a recibir ayuda gratuita por parte de un ombudsman si usted no cuenta con un abogado que lo represente en caso que se haya fijado un procedimiento de resolución de disputas.**
   Un ombudsman es un empleado de la Oficina de Asesoría Pública para el Empleado Lesionado. Un ombudsman ha sido entrenado en el campo de compensación para trabajadores para proporcionar ayuda gratis a empleados lesionados que no cuentan con un abogado. Un ombudsman no puede firmar documentos por usted, hacer decisiones por usted o dar opinión o asesoramiento legal. Los procedimientos en relación a su reclamo pueden incluir Conferencias para Revisión de Beneficios (BRC, por sus siglas en inglés) o Audiencias para Disputar Beneficios (CCH, por sus siglas en inglés). Los procedimientos se llevan a cabo en las oficinas locales de la División. En cada oficina local hay por lo menos un ombudsman.

7. **Usted tiene derecho a que la información sobre su reclamo se mantenga confidencial.**
   En la mayoría de los casos, el contenido de un expediente de reclamo no puede ser obtenido por otros. Las únicas personas que necesitan saber acerca de su reclamo son su empleador y la compañía de seguros de su empleador. También, un posible o futuro empleador puede recibir información limitada acerca de su reclamo por parte de la División de Compensación para Trabajadores.

(Ver al reverso para sus responsabilidades)

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Employee's Injury Report / Informe de lesión de empleado

This form must be completed in detail and signed by the injured employee. / El empleado lesionado debe llenar detalladamente y por completo este formulario, y firmarlo.

Your Full Name / Nombre completo		Department You Work For / Departamento en el que labora
Social Security Number (Last 4 digits only) / No. de seguro social (últimos 4 dígitos) XXXX-XX-	Date of Birth / Fecha de nacimiento	Location of Accident / Lugar del accidente
Your Address (Street, City, State, County, Zip) / Domicilio (Calle, Ciudad, Estado, Condado, CP)		Supervisor's Name / Nombre de supervisor
Phone Number Where You Can be Reached / Teléfono donde se le puede localizar		Job Title at Time of Injury / Puesto de trabajo cuando ocurrió la lesión
Date of Hire / Fecha de contratación		How Long in Current Position / Antigüedad en puesto actual Yrs. / Años Mos. / Meses

Details of the Injury / Detalles de la lesión

Date of Injury / Fecha de la lesión	Time of Injury / Hora de la lesión AM / PM	Date you first Lost Time / Fecha de inicio de la incapacidad
Where in the workplace did your injury occur? / ¿En qué parte de su trabajo ocurrió la lesión?		
Describe in detail how your injury occurred / Describa detalladamente cómo ocurrió su lesión		
What safety equipment were you using at the time of the accident? / ¿Qué equipo de seguridad usaba cuando ocurrió el incidente?		
What can be done to prevent this type of injury in the future? / ¿Qué se puede hacer para evitar este tipo de lesión en el futuro?		

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When were you first aware of this injury? / ¿Cuándo identificó la lesión por primera vez?	
When did you first notify your supervisor of your injury? / ¿Cuándo informó por primera vez de la lesión a su supervisor?	
What part of your body is injured? / ¿Qué parte de su cuerpo se lesionó?	Describe the injury. / Describa la lesión.
On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury. / En el diagrama a continuación, por favor marque con un círculo la parte o partes de su cuerpo en las que presenta dolor por esta lesión. R / D L / I L / I R / D	
Did anyone witness your accident? List the names of any witnesses. / ¿Alguien presenció el incidente? Escriba los nombres de los testigos.	
Was anyone else injured in this accident? List the names of any other injured people. / ¿Alguien más resultó lesionado en este incidente? Escriba los nombres de cualquier otro lesionado.	
In the incident that caused your injury, was there damage to any property or equipment? Describe any damage. / En el incidente que ocasionó su lesión, ¿hubo daños a la propiedad o a los equipos? Describa los daños.	

I certify that the information contained in this report is true and correct. / Declaro que la información aquí presentada es correcta y verdadera.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes. / Comprendo que la falsificación de información con respecto a una lesión laboral puede castigarse con alguna medida disciplinaria o demanda judicial de acuerdo con las Leyes Penales Estatales.

I hereby authorize the release of all medical records relating to the above noted incident to my employer, his agent or insurance company. / Por medio del presente formulario, autorizo que los registros médicos relacionados con el incidente aquí descrito sean compartidos con mi empleador, su agente o compañía de seguros.

Employee's Printed Name / Nombre completo del empleado	Employee's Signature / Firma del empleado	Date / Fecha

I certify that the above employee has acknowledged to me that he/she understood all questions and signed and dated this form in my presence this date. / Doy fe de que el empleado cuyos datos aquí se han asentado me ha indicado que comprendió todas las preguntas y que firmó y fechó este formulario en mi presencia en este día.

Witness' Printed Name / Nombre completo del testigo	Witness' Signature / Firma del testigo	Date / Fecha

Crosby ISD

EMPLOYEE CHOICE TO USE PAID LEAVE WITH WORKERS' COMPENSATION BENEFITS

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

- ☐ I choose to use only _______ days of available paid leave at this time. ***The employee will receive full pay during this time and there will be no loss of wages.***
- ☐ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or injury wage. ________ ***# of days of available leave. The employee will receive full pay during this time and there will be no loss of wages.***
- ☐ I choose not to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Crosby 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 only receive workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

____
Employee signature

____
Date

**File with Claims Administrative Services