San Felipe Del Rio CISD

Workers' Compensation Claim Information

Name of Injured Employee: _____

Last four digits of Social Security Number: XXX-XX

Date of Injury: _____

Name of Employer: San Felipe Del Rio Consolidated Independent School District

P. O. Drawer 428002, Del Rio, Texas 78842

(830) 778-4100

Workers' Comp Carrier: AmTrust Financial

P.O. Box 89453

Cleveland, OH. 44101

Toll Free Phone: 888-239-3909

Fax Number: 775-908-3724 or 877-669-9140

Adjuster: _____

Verification of Employment for a Reported Workers' Compensation Injury or Illness
(Please take this form to the doctor for your medical examination)

Employee Name _____ Date of Injury _____

Date of Birth _____ Social Security _____

Reported Work Related Injury or Illness:

_____

San Felipe Del Rio CISD workers' compensation coverage provider is AmTrust Financial. For emergencies, an injured employee may go to the nearest emergency room.

Please submit all claims and medical billing information to:

AmTrust Financial
PO Box 89453
Cleveland, OH. 44101
Phone: 888-239-3909
Fax: 775-908-3724
Pre-Authorization/UniMed
Phone: 866-931-5100
Fax: 800-281-5438

Issuing Signature_____ Title_____

Phone Number _____ Date_____

Rachel Garcia, Employee Benefits Coordinator
(830) 778-4100 Phone
(830) 778-4954 Fax
Rachel.garcia@sfdr-cisd.org

Julisa Jimenez, Employee Benefits Secretary
(830) 778-4020 Phone
(830) 778- 4954Fax
Julisa.jimenez@sfdr-cisd.org

AmTrust Financial Workers' Compensation Medical Facilities for SFDR CISD

RediMD

Walter Holmsten MD, Holmsten Family & Occupational Medicine
Family Practice, MMI/IR Certified

1730 BF Terry Blvct, Ste. 302
Rosenberg, TX 77471
Phone: (281) 633-0148
Fax: (281) 633-2298

South Texas Urgent Care Clinic

Jaime Gutierrez MD
612 N. Bedell Ave. Suite A
Del Rio, Texas 78840
Phone: (830) 775-1166
Fax: (830) 774-8554

Val Verde Regional Medical Center
(emergency care only)

801 N. Bedell Ave.
Del Rio, Texas 78840
Phone: (830) 775-8566

STAT Specialty Hospital
(emergency care only)

2600 Veterans Blvd.
Del Rio, Texas 78840
Phone: (830) 498-3000
Fax: (830) 498-0801

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.

Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree		(for transmission purposes only)	Date Being Sent
1. Injured Employee's Name		6. Clinic/Facility Name	9. Employer's Name
2. Date of Injury	3. Social Security Number	7. Clinic/Facility/Doctor Phone & Fax	10. Employer's Fax # or Email Address (if known)
4. Employee's Description of Injury/Accident		8. Clinic/Facility/Doctor Address (street address)	11. Insurance Carrier
		City State Zip	12. Carrier's Fax # or Email Address (if known)

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

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

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

☐ (b) will allow the employee **to return to work** as of _____ (date) **with the restrictions identified in PART III**, which are expected to last through _____ (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date). The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	_____
Sitting	☐	☐	☐	☐	☐	_____
Kneeling/Squatting	☐	☐	☐	☐	☐	_____
Bending/Stooping	☐	☐	☐	☐	☐	_____
Pushing/Pulling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	_____

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist

☐ L Arm ☐ R Arm ☐ Neck

☐ L Leg ☐ R Leg ☐ Back

☐ L Foot/Ankle ☐ R Foot/Ankle

☐ Other: _____

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 work / ☐ _____hours/day work:
- ☐ in extreme hot/cold environments
- ☐ at heights or on scaffolding

☐ Must keep _____:
- ☐ Elevated ☐ Clean & Dry

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No Running

16. OTHER RESTRICTIONS (if any):

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)

☐ Advised to take over-the-counter meds

☐ Medication may make drowsy (possible Safety/driving issues)

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

_____

_____

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm

☐ Referral to/Consult with_____ on _____ (date) at ____ : ____ am/pm

☐ Physical medicine __ X per week for __ weeks starting on _____ (date) at ____ : ____ am/pm

☐ Special studies (list): _____ on _____ (date) at ____ : ____ am/pm

☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:	
_____ Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ TWCC-selected RME	☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor ☐ Other doctor

FORM TWCC-73
WORK STATUS REPORT INSTRUCTIONS

PART I: GENERAL INFORMATION - Contains space to record general information about the employee and the doctor/clinic. This section includes space to record a high-level generic description of the injury or condition (e.g. broken right arm, strained left knee, etc) and how it occurred. Also contains space to record the name and facsimile number or email address of the insurance carrier (carrier) and the employer, as well as the date of transmission. This space is intended to eliminate the need for a separate facsimile cover page. **Because this information is intended primarily for transmission purposes, the report may be provided to the injured employee (employee) at the time of the examination, even if the information required in this section is not yet available.**

PART II: WORK STATUS INFORMATION - The doctor is required to indicate the employee's current work status. There are three choices: able to work without restrictions; able to work with restrictions; and prevented from returning to work.

If the doctor believes that the employee can only work with restrictions or is prevented from returning to work, the doctor is **required** to provide an estimated date of expiration for the restrictions. These estimates are required to enhance claims management and to provide the employer with information that can be used to plan work coverage and plan for the employee's return to work (whether with or without restrictions). **An estimated expiration is speculative in nature. The further the date is projected, the less accurate it may be. Estimations are not binding and may be changed as needed based upon the condition and progress of the employee by filing a subsequent Work Status Report. Doctors need to provide reasonable estimates based upon the nature of the employee's injury.**

In addition, a doctor who believes that an employee is prevented from returning to work is required to provide a specific explanation of how the condition prevents the employee from returning to work. One of the goals of the Texas Workers' Compensation Act is to ensure a speedy return to employment which is safe, meaningful, and commensurate with the abilities of the employee. **It is the responsibility of the doctor treating or examining an injured employee to identify what the employee may be able to safely perform. It is not the doctor's responsibility to ensure that the employer has a modified duty position that meets those restrictions - that is the employer's responsibility if the employer chooses to try to accommodate the restrictions.**

PART III: ACTIVITY RESTRICTIONS - If the doctor indicates that the employee is able to work with restrictions, the doctor is to indicate those restrictions in this section. **The doctor is only supposed to indicate what restrictions are in place because of the workers' compensation injury.** Any restrictions that may have existed due to other conditions are assumed to remain and should not be duplicated here. The doctor should go over the restrictions with the employee at the time the report is provided.

The section was designed to include check boxes for common restrictions that may apply to the employee. If a box is not checked, it is assumed that there is no restriction on that activity. Also, if no specific body part is indicated in box #15, then it should be understood that the restrictions are whole body restrictions.

PART IV: DIAGNOSIS/FOLLOW-UP INFORMATION - Provides general diagnosis information and provides upcoming appointment information (if known at time of filing report) so that the carrier can better manage the claim and the employer can be aware of time where the employee might not be available for work. In addition, providing this information may reduce calls from carriers and employers seeking the information. **However, doctors need ensure that the diagnosis information provided to the employer is at a general level and does not violate any confidentiality laws relating to the employee's privacy rights.**

The Work Status Report is primarily designed to be filed by the treating or referral doctor. However, other doctors can and will occasionally need to file this report. The following describes the various roles that doctors can play within the system:

Treating: Doctor chosen by and primarily responsible for employee's injury-related health care.	***Referral***: Doctor who was selected by the treating doctor to treat one or more aspects of the employee's medical condition.
Consulting: Doctor who was selected by the treating doctor to provide an opinion on the employee's medical condition.	***Carrier-selected RME:*** Doctor selected by the insurance carrier.
Designated: Doctor selected by the Commission to evaluate whether the employee's medical condition has improved sufficiently to allow a return to work (only for Supplemental Income Benefits claims).	***TWCC-selected RME:*** Doctor selected by TWCC.
	Other: Doctor who fits none of the other descriptions.

Basic Instructions - Provide to injured employee at time of examination and fax or electronically transmit to: insurance carrier and employer by the end of the second working day following the date of the examination. Report must be filed after initial visit, when there is a change in work status or a substantial change in activity restrictions, and on the schedule requested by or through the carrier (not to exceed one report every two weeks). Also file within 7 days of receiving functional job descriptions from the employer or a Work Status Report from a Required Medical Examination doctor that indicates that the employee is able to return to work with or without restrictions.

Rules 126.6, 129.5, and 130.110 lay out the complete requirements for filing this report (in addition, Rule 129.6 provides information on how the report might be used). The complete text to these rules is available on the Commission's web site at www.twcc.state.tx.us.

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America — CARRIER/TPA

San Felipe Del Rio CISD — EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist — SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

Am Trust North America — PORTADORA
San Felipe Del Rio CISD — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL

FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

San Felipe Del Rio CISD
SUPERVISOR'S INVESTIGATION REPORT

Name of Employee:

Campus/Department: Position:

Years / Month on Job Date of Injury: Time of Injury:

What Happened: (Describe what took place at time of injury)

Why did it happen? (Study the accident, situation and job duties)

What should be done? (Determine what measures should be taken to keep this from happening)

What have you done thus far? (Taken or recommended action, follow up)

How will this improve operations? (Objective to eliminate job hindrances)

Investigated by: Title:

Please print name

Date Investigated:

Reviewed by: Date Reviewed:

This form must be completed by the injured worker's Supervisor and e-mailed to Employee Benefits and Support Services Department.

**If the employee sees a Doctor, the Doctor's note must be taken to Support Services before the employee can return to work. Light duty will be evaluated on a case by case basis.

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

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 (OIEC). 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 and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose 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. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however, changing your treating doctor must be pre-approved by the DWC if you are not in a network. 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.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation 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 DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. 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. If there is something you do not understand, ask your employer or call OIEC. 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.texas.gov/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 providers 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 Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
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 DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

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

En Texas, usted como empleado lesionado tiene derecho a recibir ayuda gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel -OIEC, por su nombre y 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 (Texas Department of Insurance -TDI, por su nombre y siglas en inglés). TDI, es la agencia estatal que regula y administra el sistema de compensación para trabajadores mediante la División de Compensación para Trabajadores (Division of Workers' Compensation - DWC, por su nombre y siglas en inglés).

Muchos de los servicios que son proporcionados por parte de OIEC y de DWC pueden ser llevados a cabo por teléfono. Usted puede comunicarse con OIEC llamando al teléfono gratuito 1-866-EZE-OIEC (1-866-393-6432). Visite el sitio Web de OIEC en www.oiec.texas.gov, para obtener información adicional, incluyendo la ubicación de las oficinas. Usted puede comunicarse con DWC llamando al teléfono gratuito 1-800-252-7031. La información de DWC se encuentra disponible en la página de Internet: www.tdi.texas.gov.

Sus Derechos Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene derecho a contratar a un abogado para asistirle con su reclamación de compensación para trabajadores.**
   Para obtener asistencia para encontrar a un abogado, llame al servicio de recomendación de abogados de la Barra de Abogados del Estado de Texas (State Bar of Texas, por su nombre en inglés) al 1-877-983-9227 o visite www.texasbar.com. La información sobre la recomendación de abogados también puede encontrarse en la página de Internet de OIEC en www.oiec.texas.gov.

2. **Usted tiene derecho a recibir asistencia por parte de OIEC si no cuenta con un abogado.**
   Los Representantes de Servicio al Cliente de OIEC, así como los Ombudsman están disponibles para responder a sus preguntas y proporcionarle asistencia con su reclamación de compensación para trabajadores ya sea llamando a OIEC o visitando una de las oficinas de OIEC. **Usted debe firmar una autorización por escrito antes que un empleado de OIEC pueda tener acceso a la información sobre su reclamación.** Llame o visite una oficina de OIEC para completar la autorización por escrito. Los Representantes de Servicio al Cliente de OIEC y los Ombudsman han sido entrenados en el campo de compensación para trabajadores y pueden ayudarle a programar un procedimiento de resolución de disputas, relacionado con su reclamación de compensación para trabajadores. Un ombudsman también puede asistirle en una Conferencia para Revisión de Beneficios (Benefit Review Conference –BRC, por su nombre y siglas en inglés), en una Audiencia para Disputar Beneficios (Contested Case Hearing –CCH, por su nombre y siglas en inglés), y en una apelación. Sin embargo, un Ombudsman no puede tomar decisiones por usted, ni dar opiniones por usted o proporcionar asesoramiento legal.

3. **Con ciertas excepciones, usted tiene derecho a recibir beneficios médicos y beneficios de ingresos sin importar quién tuvo la culpa de su lesión. Sus beneficiarios podían tener derecho a recibir beneficios por causa de muerte y beneficios de gastos para el entierro.**
   La información sobre las excepciones puede encontrarse en www.tdi.texas.gov o consultando al personal de OIEC.

4. **Usted puede tener derecho a recibir atención médica para atender su lesión o enfermedad que sucedió en el área de trabajo, durante todo el tiempo que sea médicamente necesario y relacionado con la lesión que sucedió en el área de trabajo.**
   Usted puede tener derecho a recibir un reembolso por los gastos incurridos después de viajar para asistir a una cita médica o a un examen médico requerido (required medical examination, por su nombre en inglés), si el viaje cumple con las condiciones de calificación.

5. **Usted puede tener derecho a recibir beneficios de ingresos por su lesión relacionada con el trabajo.**
   Existen varios tipos de beneficios de ingresos, así como requisitos de elegibilidad. La información sobre los tipos de beneficios de ingresos que pueden estar disponibles, y los requisitos de elegibilidad pueden ser encontrados en www.tdi.texas.gov o consultando al personal de OIEC.

6. **Usted puede tener derecho a una resolución de disputas con respecto a sus beneficios de ingresos y beneficios médicos.**
   Usted puede solicitar una Resolución de Disputas Médicas (Medical Dispute Resolution, por su nombre en inglés) si está en desacuerdo con la aseguradora sobre los beneficios médicos. Usted puede solicitar una Resolución de Disputas por Indemnización (Ingresos) (Indemnity (Income) Dispute Resolution, por su nombre en inglés), si está en desacuerdo con la aseguradora sobre los beneficios de ingresos. La ley establece que sus procedimientos de resolución de disputas sean llevados a cabo dentro de 75 millas del domicilio suyo.

7. **Usted tiene derecho a escoger a su médico de tratamiento.**
   Si usted pertenece a una red de servicios médicos de compensación para trabajadores (Workers' Compensation Health Care Network), (red), debe escoger a su médico de la lista de médicos de tratamiento de la red. Usted puede cambiar a su médico de tratamiento una sola vez sin la necesidad de obtener la aprobación de la red. Si no pertenece a una red, usted puede inicialmente escoger a cualquier médico que esté dispuesto a atender su lesión de compensación para trabajadores; sin embargo, si usted no pertenece a una red, el cambio de su médico de tratamiento debe ser pre-aprobado por DWC. Si es empleado de una subdivisión política, tal como la ciudad, el condado, o el distrito escolar, usted deberá seguir los reglamentos de dicha subdivisión política para escoger a un médico de tratamiento. Es importante seguir todos los reglamentos en el sistema de compensación para trabajadores. **Si usted no sigue estos reglamentos, podría ser considerado responsable por el pago de las facturas médicas.** El personal de OIEC puede ayudarle a entender estos reglamentos.

8. **Usted tiene derecho a que la información sobre su reclamación de compensación para trabajadores se mantenga confidencial.**
   En la mayoría de los casos, el contenido del expediente de su reclamación no puede ser obtenido por otras personas. Algunos participantes tienen derecho a conocer el contenido del expediente de su reclamación, tal como su empleador o la aseguradora de su empleador. También, un empleador que esté considerando contratarle a usted puede obtener información limitada por parte de DWC sobre su reclamación.

Sus Responsabilidades Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene la responsabilidad de informar a su empleador si se ha lesionado en el trabajo mientras desempeñaba sus deberes de trabajo. Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o del día en que usted se dio cuenta que su lesión o enfermedad podría estar relacionada con su trabajo.**

2. **Usted tiene la responsabilidad de saber si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores (red) (Workers' Compensation Health Care Network -network).**
   Si no sabe si pertenece a una red de servicios médicos, pregúntele al empleador para el cual usted trabajaba al momento en que ocurrió su lesión. Si pertenece a una red, es su responsabilidad seguir los reglamentos de dicha red. Si usted encuentra algo que no entiende, pregunte a su empleador o llame a OIEC. Si desea presentar una queja sobre una red, llame a la Línea de Ayuda al Consumidor de TDI (TDI's Consumer Help Line, por su nombre en inglés) al 1-800-252-3439 o presente su queja en línea en www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **Si usted trabajó para una subdivisión política (p. ej. la ciudad, el condado o el distrito escolar) al momento en que sucedió su lesión, es su responsabilidad averiguar cómo recibir tratamiento médico.**
   Su empleador debe poder proporcionar la información que usted necesita para determinar cuáles son los proveedores de servicios médicos que pueden atender su lesión relacionada con el trabajo.

4. **Usted tiene la responsabilidad de informar a su médico cómo es que usted se lesionó y determinar si la lesión está relacionada con el trabajo.**

5. **Usted tiene la responsabilidad de completar y enviar a DWC el Formulario DWC-041, Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional.**
   Usted cuenta con un año para enviar el formulario después de haberse lesionado o después de haberse enterado que su enfermedad podría estar relacionada con su trabajo. Complete y envíe el Formulario DWC-041 aun si ya está recibiendo beneficios. Usted puede perder su derecho a recibir beneficios si no envía a tiempo el formulario completo a DWC. Para obtener una copia del Formulario DWC-041 comuníquese con DWC o con OIEC.

6. **Usted tiene la responsabilidad de proporcionar su dirección actual, número de teléfono e información sobre su empleador a DWC y a la aseguradora. Usted puede comunicarse con DWC al 1-800-252-7031.**

7. **Usted tiene la responsabilidad de informarle a DWC y a la aseguradora cada vez que haya un cambio en el estado de su empleo o su salario.**
   (Algunos ejemplos de cambios incluyen: si deja de trabajar a causa de su lesión; si usted regresa a trabajar; o si recibe una oferta de trabajo).

8. **Los beneficiarios que son elegibles o las personas que buscan obtener beneficios por causa de muerte o beneficios de gastos para el entierro, tienen la responsabilidad de completar y enviar a DWC el Formulario DWC-042, Reclamación del Beneficiario para Obtener Beneficios por Causa de Muerte dentro de un año, a partir de la fecha en que el empleado falleció.**

9. **Usted tiene prohibido hacer reclamaciones o demandas injustificadas o fraudulentas.**

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Wage and Hour Division