Revised 5/14/2019

SOCORRO INDEPENDENT SCHOOL DISTRICT

Accident/Incident Report For Work Related Injuries

Section I: Accident Report

Date: _____

Name of Injured Employee: _____ Male ☐ Female ☐

Employee Number: _____ DOB: _____ Date of Hire: _____

School/Dept.: _____ School/Dept. Phone #: _____

Job Title: _____ Supervisor: _____

Employee's Home Address: _____

City/State/Zip: _____ Phone Number: _____

Date of Injury: _____ Time of Injury: _____

Nature of Injury (e.g.: fall, cut, burn, etc.): _____

Body Part(s) injured: _____

(Also circle injured body part(s) on the second page of this form)

Describe how injury/illness occurred: _____

_____

_____

_____

_____

- I hereby certify that the information above and on the second part of this form is true and correct to the best of my knowledge.
- I understand that any falsification of the information regarding on the job injury or illness may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

_____ _____

Employee Signature Date

Note: If report was not filled out by the injured employee please indicate name and title of person completing the report and sign & date where indicated.

_____ _____

Name Title

_____ _____

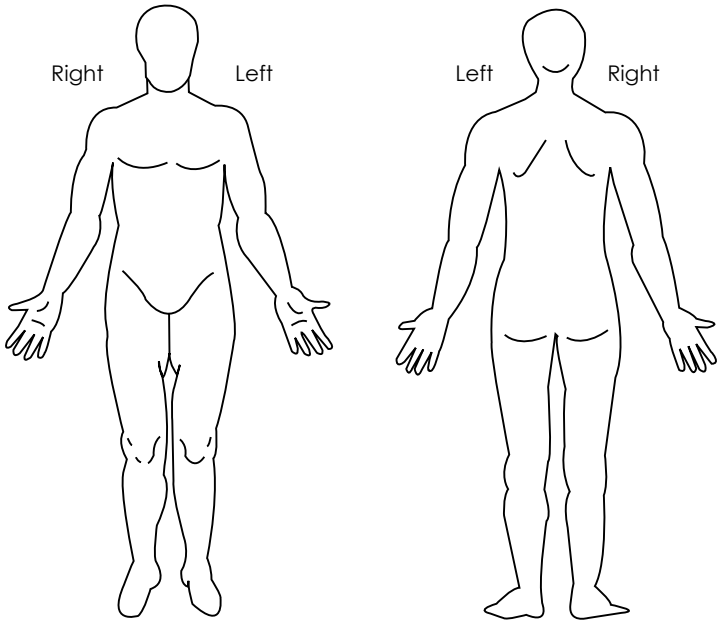
Signature Date

SOCORRO INDEPENDENT SCHOOL DISTRICT

Accident/Incident Report For Work Related Injuries

Return this form to:
Socorro Independent School District
Risk Management Division
12440 Rojas Drive, El Paso Texas 79928
Phone Number: (915) 937-0251
Fax Number: (915) 851-7934

On the diagram below, please circle the part(s) of your body where you are experiencing pain due to this injury



Employee Signature _____ Date _____

Supervisor's Signature _____ Date _____

Employee does not feel medical treatment is necessary at this time

☐ **YES** ☐ **NO**

SOCORRO INDEPENDENT SCHOOL DISTRICT

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SECTION II: Witness - (to be completed by **WITNESS ONLY**)

Name of Witness: _____ Job Title: _____

Name of Injured Employee: _____ Date of Injury: _____

Did you see the incident occur? ☐ YES ☐ NO

Was medical treatment required? ☐ YES ☐ NO

Was first aid administered? ☐ YES ☐ NO

If yes, by whom? _____

List body part(parts) injured: _____

_____

Describe what you saw: _____

_____

_____

- I hereby certify that the information above is true and correct to the best of my knowledge.
- I understand that any falsification of the information regarding an on-the-job injury or illness may result in disciplinary action and/or prosecution under the appropriate State Criminal Statues.

_____ _____

Employee Signature Date

Return this form to:

Socorro Independent School District
Risk Management Division
12440 Rojas Drive, El Paso Texas 79928
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SOCORRO INDEPENDENT SCHOOL DISTRICT

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Section III: Request To Use Available Personal Leave

It is the employee's responsibility to report absences due to a work-related injury (workers' comp.)
YOU MUST CALL IN ANY LOST TIME TO ABSENCE MANAGEMENT

REQUEST TO USE AVAILABLE PERSONAL LEAVE
(Please print all information)

Employee Name: _____

Employee Number: _____ Position: _____

Employees who receive workers' compensation benefits, whether or not they are on FMLA (Family Medical Leave Act), have the option of using any available personal leave when they are receiving workers' compensation benefits. Should you receive workers' compensation benefits due to a work-related injury or illness, you may elect to use or not use your personal leave while receiving these benefits.

Do you request to use your available leave?

☐ **YES** ☐ **NO**

_____ _____
Employee Signature Date

* Note: If you do not complete this portion or leave blanks, the District **WILL NOT** use your days and you may be docked pay.

HIPAA Authorization for Disclosure of Protected Health Information

I, _____, date of birth _____, authorize the disclosure of my protected health information* as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws**, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below): *All healthcare providers who have provided healthcare to me.*
2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organization(s) above.

   Name: **Claims Administrative Services, Inc.**
   PO. Box 7500
   Tyler, Texas 75711

   Texas Dept. of Insurance - Division of Workers' Compensation
   7551 Metro Center Drive, Suite 100
   Austin, Texas 78744-1609

   Other: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

   I further specifically authorize the disclosure of psychotherapy notes, if any.

4. The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.
6. I understand that treatment and payment for my treatment are not conditioned on my agreement to this authorization.

   'Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be the protected, the information must be such that it identifies individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

   ****These laws apply to health plans, health care providers, and health care clearinghouses.**

7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.
8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/ or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis, testing or treatment.
9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first. I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

_____

Name Address Telephone DOB

_____ _____

Employee Signature Date

SOCORRO INDEPENDENT SCHOOL DISTRICT

Accident/Incident Report For Work Related Injuries

Section IV: Nurse Notes/Comments

Employee Name: _____

Date: _____

Campus: _____

Notes/Comments: _____

_____

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_____

Nurse's Signature