For the Edna ISD injured employee

Report of **Voluntary** Use of Leave Entitlement to Temporary Income Benefits

Per Rule 129.2 of the Texas Workers' Compensation Act, an employee's entitlement to temporary income benefits may be affected by voluntary use of accrued leave after an on-the-job injury. The value of accrued sick/annual leave is considered by the Division of Workers' Compensation (DWC) to be post-injury earnings and if those earnings (the value of the leave time) equal or exceed your average weekly wage, you will be considered to have lost no wages and the workers' compensation carrier will not be required to pay temporary income benefits to you.

This is only applicable if you **voluntarily** elect to use your accrued leave instead of receiving workers' compensation benefits and is only applicable for the amount of accrued leave time that you choose to utilize.

The **choice** in this matter is **solely** yours, the **employee**. Employers may not arbitrarily mandate employees to use accrued leave time in order to minimize the usage of the employer's workers' compensation coverage.

Please be aware that workers' compensation benefits are based on compensable disability, your average weekly wage at a percentage of either 70% or 75% dependent on your hourly rate, and subject to a minimum/maximum rate as established by the DWC.

Please complete the following information to affirm the voluntary use of accrued leave benefits after an on-the-job injury.

Employee's Name (Last, First, MI)	**Social Security No.** XX-XXX-	**Date of Injury** (mm/dd/yyyy)
Date Lost Time Began: (mm/dd/yyyy)	**Accrued Sick/Annual Leave Use?:** ☐ Yes, I elect to use my available accrued leave. ☐ No, I do NOT elect to use my leave and understand I will be placed on leave without pay. I understand workers' compensation benefits will begin on the 8th day of disability and that days 1 – 7 of disability will not be issued unless and until I have reached 14 days of disability.	**Total Leave Available:** _____ **Number of Days to be Used:** _____ **Dates Leave To be Used** (mm/dd/yyyy): Beginning: _____ Ending: _____ **Gross Value of Leave:** Daily: _____ Weekly: _____

The information above is accurate to the best of my knowledge. It may be relied upon for evaluation of my eligibility for benefits.

_____ _____

Employee Signature **Date**

_____ _____

Printed Name and Signature of Employer Representative **Date**

'Verbal' election due to the employee's inability to physically sign.

Reason employee is unable to physically sign: _____

Verbal election given to above employer representative on this date/time: _____

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 filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☐
3. Social Security Number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*
19. Part of Body Injured or Exposed*
20. How and Why Injury/Illness Occurred*
21. Was employee doing his regular job? YES ☐ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*
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
24. Cause of Injury(fall, tool, machine, etc.)*
25. List Witnesses
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) - -

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 ( )
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street
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 _____

[Employer: Please provide this form to your employee upon notification of injury.]
[Employee: Please provide this form to your treating doctor and/or pharmacy on your initial visit.]

Health Care Provider
Injury Notification Form

Attention: Healthcare Provider

Please be advised that the below employee has claimed a workers' compensation injury or illness.

Employee Name	
SSN	
Date of Injury	

You may provide reasonable, necessary and related medical treatment for the claimed injury or illness. Treatment must be within the Texas Official Disability Guidelines (ODG) for the sustained injury or illness. If the treatment recommended is not within the (ODG), then preauthorization is required. Please note, per §134.501 pharmaceutical services dispensed within the first 7 days are covered and cannot be denied, prorated or reduced.

Please do not request payment from the injured employee. Your services should be billed to the below workers' compensation third party administrator:

Edwards Claims Administration
1004 Marble Heights Drive
Marble Falls, TX 78654
Phone: 830-693-2728
Fax: 830-693-2729

Please note: ECA does NOT have a network.

Treatment requiring preauthorization should be sent to the workers' compensation third party administrator's utilization review organization:

Starr Comprehensive Solutions
Phone: 866-462-4197
Fax: 713-462-4143

Prior to the injured employee leaving your office, please distribute a DWC-73 (Work Status Report) per Workers' Compensation Rules.

1. Injured employee at the time of the examination via hand delivery
2. Edwards Claims Administration within 2 working days via fax: 830-693-2729
3. Edna ISD within 2 working days via fax: 361-781-1002

For further questions or confirmation of this injury or illness you may contact our workers' compensation coordinator Jan Wooldridge at 361-782-3573.

Thank you,