Galveston Independent School District
3904 AVE T, Galveston Texas 77551
Phone: 409-766-5100 Fax: 409-762-0677

Workers' Compensation Injury Instructions

The following information must be completed for all Workers' Comp injuries regardless of whether medical attention is needed:

- First Report of Injury – must be completed online immediately by campus nurse or designated campus contact. To fill out a First Report of Injury go to **www.tasbrmf.org**

The following must be completed if seeking medical treatment:

- Verification of Employment for Reported Workers' Compensation Injury or Illness – completed by designated personnel and given to employee **immediately** to take with them to the treating facility
- OPTUM Prescription Card - Completed by campus/department designated personnel and given to employee **immediately** before employee leaves for treatment for initial prescription fill at no cost to the employee

The following must be completed and sent to the Benefits office:

- Employee Acknowledgment of the Alliance – Must be signed by employee and returned **Immediately** to the benefits office.
- Election of Leave Benefits with Workers' Compensation – Must be completed, signed by the employee and sent **immediately** to the benefits office.

This report will be completed by a treating physician:

- Texas Workers' Compensation Work Status Report – Must be completed each time the employee is seen by a physician/clinic. Please see instructions below based on box selected by physician
    a. Medical Treatment Only – before returning to work this must be completed by the attending physician releasing the employee to work
    b. Medical Treatment and Absence from Duty – this form must be completed at each visit to the attending physician detailing any restrictions and when released to full duty
    c. This form must be given to the benefits office **immediately via fax or email**
    d. It is the employee's responsibility to communicate with the benefits coordinator following each doctor's visit to make sure all information has been received

For Employee Information (give these copies to the employee):

- Employee Notice of Alliance Requirements
- Notice of Injured Employee Rights and Responsibilities

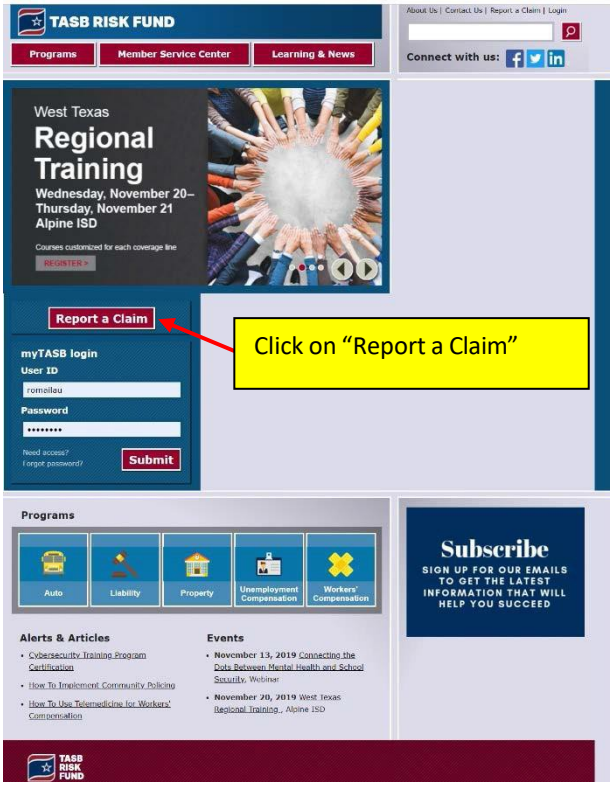
For any questions relating to Workers' Compensation please contact
Micaela Mirelez, Payroll/Benefits Clerk
409-766-5128 or micaelamirelez@gisd.org

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

TASB RISK FUND

How to File a First Report of Injury

Go to this link. If link isn't working go to www.tasbrmf.org:



You are now at the Online First Report of Injury. You may want to bookmark this page so you can go directly to it in the future:

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Please select your district from the list below then click the submit b

Member Name

Select your district from the drop down menu and hit submit.

Submit

For additional information or questions, please e-mail us.

TASB RISK MANAGEMENT FUND

The new tasbrmf.org: Simply better

See it now!

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Don't file an amended or corrected copy. If you've submitted and need to make a change, contact Human Resources.

Asterisks denote required information for this report to be properly processed.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

EMPLOYER GENERAL INFORMATION

Employer Name	Education ISD
Street Address Line 1:	123 First Drive
Street Address Line 2:	
City, State, Zip:	Your City, TX 00000
Mailing Address Line 1:	PO Box ABC
Mailing Address Line 2:	
City, State, Zip:	Your City, TX 00000
Tax ID Number:	74-xxxxxxxxx
Phone Number:	(555) 555-1212
SIC Code:	
Insured Report Number:	
Campus Code*:	
Department Code: (if applicable)	

Some members use this for Employee numbers. You may leave this blank

Select employee's location or campus code from drop down menu.

If there is a Department code choose from the drop down list.

EMPLOYEE INFORMATION

Employee Name (Last, First, MI)*:

Street Address*: 1

Street Address:

City, State, ZIP*: Your Town | TX | 11111

Phone*: 111 - 111 - 1111

Date of Birth *(example: xx/xx/xxxx)**: 01/01/2010

Social Security Number*: 111111111

Date Hired *(example: xx/xx/xxxx)**: 01/01/2010

State of Hire*: TX

Sex*: Male | Female | Unknown

Marital Status*: Unmarried | Married | Separated | Unknown

Occupation/Job Title*:

Employment Status*: Regular Employee

# of Dependents:

Please make every effort to get employee's current mailing address. If unknown, please use address in this example.

If unable to get current phone number, please use 111-111-1111.

If unknown, please use 01/01/2010

If unknown, please use 111-11-1111

Occupation Codes:
010 - Professional/Clerical/Administration
020 - Building Maintenance
030 - Food Service
040 - Custodial
050 - Driver & Vehicle Maintenance
060 - All Other
Example – 030/Cafeteria Cashier

Select either Regular or Part Time

WAGE INFORMATION

Rate - 0.00 :

Per*: Week | Bi-Weekly | Semi-Monthly | Month | Hour | Daily

Please use 1.00

Days Worked/Week*:

Full Pay for Day of Injury? Yes | No

Did Salary Continue? Yes | No

Gross Amount of Last Paycheck - 0.00: 0

Type of Pay: Weekly | Bi-Weekly | Semi-Monthly | Monthly

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits? Yes | No | Unknown

If so, how many leave hours have they elected to use?

Leave this blank.

OCCURRENCE INFORMATION

Type of Claim*: ○ Record Only ○ Medical Only ○ Lost Time

Date of Injury/Illness *(example: xx/xx/xxxx)**:

Time Employee Began Work *(example: 08:15)**: ◉ AM ○ PM

Time of Occurrence *(example: 08:15)**: ◉ AM ○ PM

Last Work Date *(example: xx/xx/xxxx)*:

Date Employer Notified *(example: xx/xx/xxxx)**:

Date Disability Began *(example: xx/xx/xxxx)*:

Supervisor Name:

Supervisor Phone Number: - -

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Did injury/illness exposure occur on employer's premise? ◉ Yes ○ No

Department or Location where accident or illness exposure occurred*:

All equipment, material or chemicals employee was using when accident or illness exposure occurred:

Specify activity the employee was engaged in when the accident or illness exposure occurred*:

Work process the employee was engaged in when accident or illness exposure occurred:

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill*:

Date Returned to Work *(example: xx/xx/xxxx)*:

If Fatal, Give Date of Death *(example: xx/xx/xxxx)*:

Were Safeguards or Safety Equipment Provided? ◉ Yes ○ No

Were they used? ◉ Yes ○ No

Record Only – No lost time, No treatment expected, No questions
Medical Only – Currently working, no more than 3 days of lost time, no questions
Lost Time – All others

Complete ONLY if employee is not at work.

This is the date the secretary, principal, nurse or supervisor first knew of incident.

First date of work missed due to injury. (**This is never the date of injury**.) Leave blank if there was no lost time.

Consult the code lists below. Select the code most applicable. Cuts are lacerations, bruises are contusions.

Example: Reagan Elementary cafeteria or playground. If it did not occur on employer premises, enter address or location. Be sure to note if it's a different location than above.

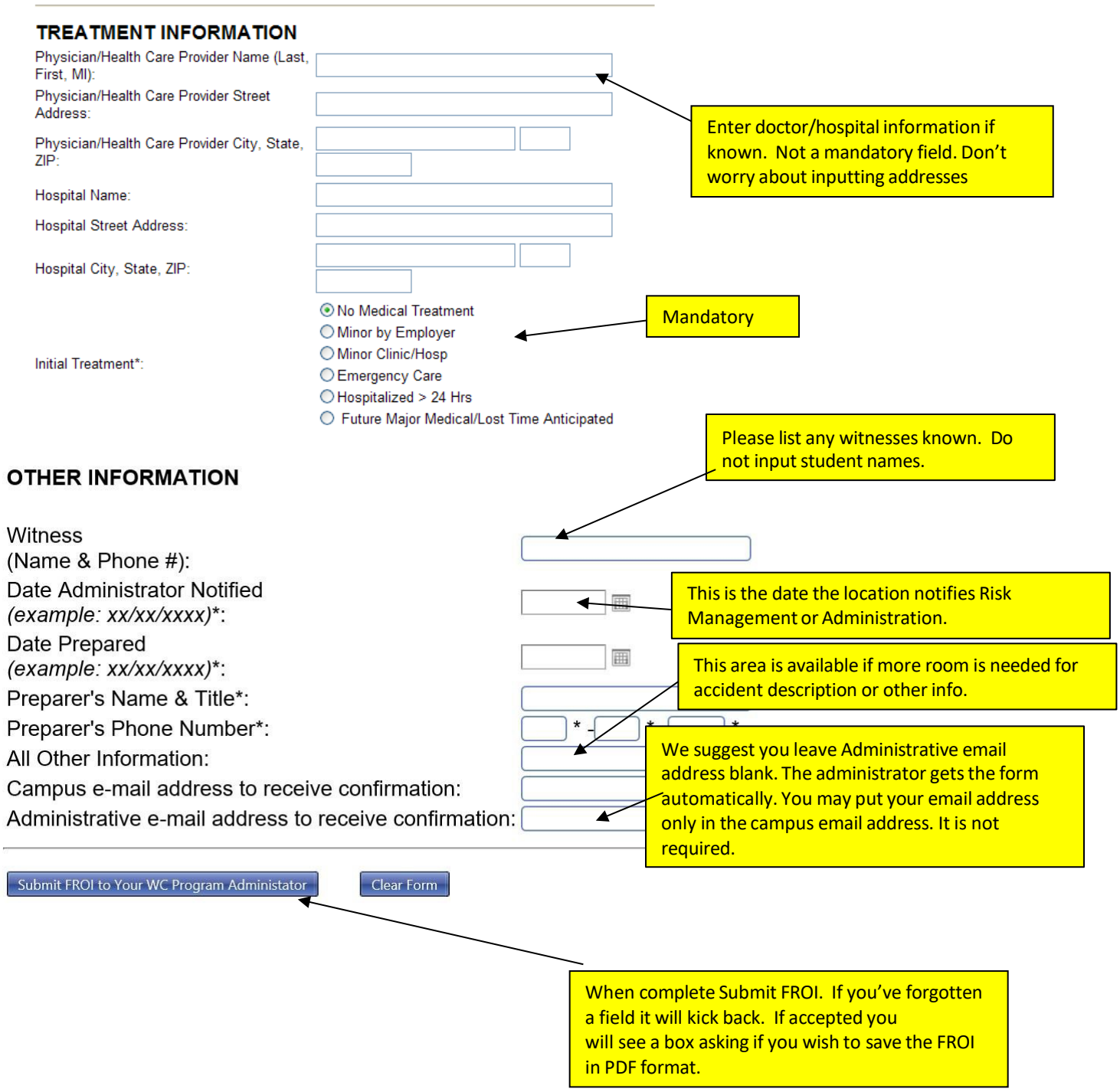
List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.

Activity when accident occurred such as cooking, teaching, walking, etc.

The work process employee was doing such as teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.

How injury occurred or was reported by employee. Be short and to the point. Clarify body part and side of body, ex. "Student bit employee on right hand between thumb and index finger."

Date employee actually returned to work. Leave blank if employee is still not working. (NO FUTURE DATES.)


TREATMENT INFORMATION
Physician/Health Care Provider Name (Last, First, MI):
Physician/Health Care Provider Street Address:
Physician/Health Care Provider City, State, ZIP:
Hospital Name:
Hospital Street Address:
Hospital City, State, ZIP:
Initial Treatment*:
No Medical Treatment
Minor by Employer
Minor Clinic/Hosp
Emergency Care
Hospitalized > 24 Hrs
Future Major Medical/Lost Time Anticipated
Enter doctor/hospital information if known. Not a mandatory field. Don't worry about inputting addresses
Mandatory
OTHER INFORMATION
Please list any witnesses known. Do not input student names.
Witness (Name & Phone #):
Date Administrator Notified (example: xx/xx/xxxx)*:
This is the date the location notifies Risk Management or Administration.
Date Prepared (example: xx/xx/xxxx)*:
Preparer's Name & Title*:
Preparer's Phone Number*:
This area is available if more room is needed for accident description or other info.
All Other Information:
Campus e-mail address to receive confirmation:
Administrative e-mail address to receive confirmation:
We suggest you leave Administrative email address blank. The administrator gets the form automatically. You may put your email address only in the campus email address. It is not required.
Submit FROI to Your WC Program Administator
Clear Form
When complete Submit FROI. If you've forgotten a field it will kick back. If accepted you will see a box asking if you wish to save the FROI in PDF format.

TASB RISK FUND™

TASB Risk Management Fund Homepage

Workers' Compensation

You've successfully submitted a First Report when you see this page. Click on the link to see the report in PDF Format.

First Report of Injury or Illness

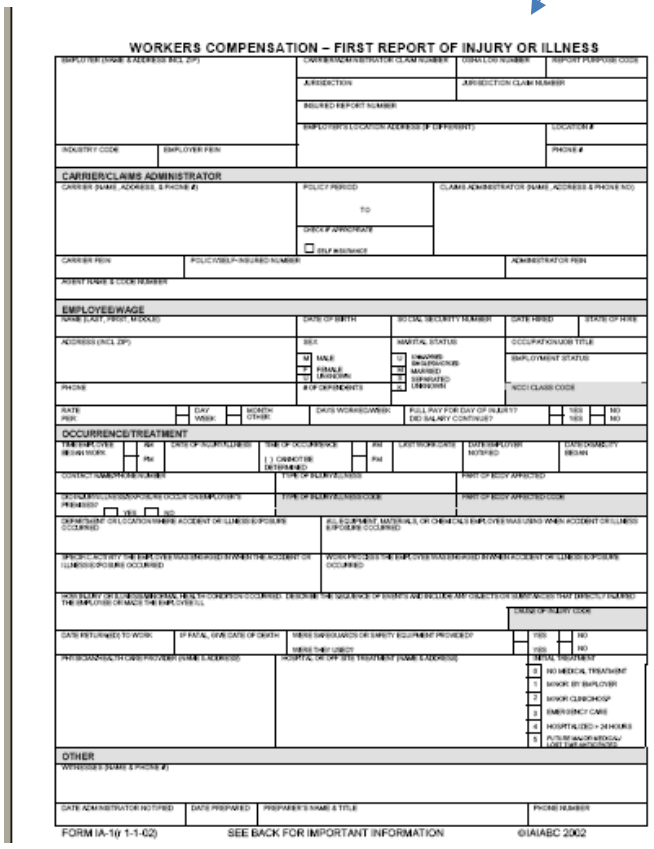
The First Report of Injury for **Doe John** has been sent to the Member WC Claim Administrator.

Click here to print the First Report of Injury in IA-1 Format.

(Please allow popup windows from your browser. The IA-1 form will appear in a separate window. This process may take a few minutes to run.)

Download FROI/Excel Format | Download FROI/Text Format

PO Box 400, Austin, Texas 78767-0400 • 512.467.0222



WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

CARRIER/CLAIMS ADMINISTRATOR

EMPLOYEE/WAGE

OCCURRENCE/TREATMENT

OTHER

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION ©IAIABC 2002

Nature of Injury

01 No Physical Injury	37 Inflamation	64 Silicosis
02 Amputation	40 Laceration	65 Respirtory Disorders (Fumes)
03 Angina Pectoris	41 Myocardial Infraction	66 Poisoning-Chemical: Not Metals
04 Burn	42 Poisoning-Not OD or Cumulative	67 Metal Poisoning
07 Concusion	43 Puncture	68 Dermatitis
10 Contusion	46 Rupture	69 Mental Disorder
13 Crushing	47 Severance	71 All Other Occupation Disease
16 Dislocation	49 Sprain	72 Loss of Hearing
19 Electric Shock	52 Strain	73 Contagious Disease
22 Enucleation	53 Syncope	74 Cancer
25 Foreign Body	54 Asphyxiation	75 Aids
28 Fracture	55 Vascular Loss	76 VDT - Related Disease
29 Not Used	58 Vision Loss	77 Mental Stress
30 Freezing	59 All Other	78 Carpel Tunnel Syndrome
31 Hearing Loss or Impairment	60 Dust Disease NOC	80 All Other Cumulative Injuries
32 Heat Prostration	61 Asbestosis	90 Mulitiple Inj - Physical Only
34 Hernia	62 Black Lung	91 Multiple Inj - Physical Psych
36 Infection	63 Byssinosis	

19 Cut/Scrape Miscellaneous	58 Strain/Injury: Reaching	90 Not a Physical Cause of Injury
20 Collapsing Materials	59 Strain/Injury: Using Tool/Mach	94 Rubbed/Abraded:Repetitive Motion
25 Fall/Slip From Diff. Level	60 Strain/Injury: Miscellaneous	95 Rubbed/Abraded: Miscellaneous
26 Fall/Slip From Ladder/Scaffold	61 Strain/Injury: Wield or Throw	97 Strain/Injury: Repetitive Motion
27 Fall/Slip From Grease/Liquid	65 Strike/Step Moving Parts	98 Cumulative (All Other)
28 Fall/Slip: Into Openings	66 Strike/Step Obj Lifted/Used	99 Other

Body Part Injured

10 Multiple Head Injury	32 Elbow	51 Hip
11 Skull	33 Lower Arm	52 Upper Leg
12 Brain	34 Wrist	53 Knee
13 Ear(s)	35 Hand	54 Lower Leg
14 Eye(s)	36 Finger(s)	55 Ankle
15 Nose	37 Thumb	56 Foot
16 Teeth	38 Shoulder(s)	57 Toe(s)
17 Mouth	39 Wrist(s) and Hand(s)	58 Great Toe
18 Soft Tissue: Head	40 Multiple Trunk	60 Lungs
19 Facial Bones	41 Upper Back Area (Thoracic)	61 Abdomen Including Groin
20 Multiple Neck Injury	42 Lower Back (Lumbar/Lumbo-Sacral)	62 Buttocks
21 Neck Vertebrae	43 Disc: Trunk	63 Lumber and or Sacral Vertebra
22 Neck Disc	44 Chest, Ribs, Sternum, Soft Tissue	64 Artificial Appliance
23 Spinal Cord (Neck)	45 Sacrum and Coccyx	65 Insufficient Info to Identify
24 Larynx	46 Pelvis	66 No Physical Injury

25 Soft Tissue: Neck	47 Spinal Cord	90 Multiple Body Parts
26 Trachea	48 Internal Organs	91 Body Systems-Single and Multiple
30 Multiple Upper Extremities	49 Heart	99 Whole Body Impairment
31 Upper Arm, Clav. Scapula	50 Multiple Lower Extremities	