

CITY OF SAN ANTONIO

Risk Management Division



WORKERS' COMPENSATION & MODIFIED WORK ASSIGNMENT PROCEDURES MANUAL

Risk Management Division

Mission Statement



Our Mission

The Division of Risk Management is comprised of three components collectively working together to protect the City of San Antonio's asset, and guard against risks and safety hazards that could adversely impact City operations. Risk Management is also committed to providing a safe and healthy environment for the protection of City employees and the public.

Our Goals

The Risk Management Division shall deliver to the City a quality Risk Management program that focuses on the prevention of injuries, the protection of City assets, the development and implementation of sound safety programs, and the protection of human lives.

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Administrative Directives

- ◆ *AD 4.37 – Modified Duty Work Assignment Program for Work-Related Illnesses or Injuries*
- ◆ *AD 4.84 – Workers' Compensation Program*

Section I

Workers' Compensation Overview

Policy Guidelines

The City of San Antonio ("City") became subject to the Texas Workers' Compensation Act in July 1974. The Act requires the City to pay certain benefits to an employee who sustains an injury or develops an occupational illness or disease within the course and scope of employment. Benefits are also provided to dependents in cases where employees have sustained injuries resulting in death.

The Risk Management Division (RM) of the Finance Department manages all Workers' Compensation claims through a Third Party Administrator (TPA). The TPA is responsible for recording and transmitting all information related to claims, serves as liaison between departments, medical providers, and claimants, authorizes rehabilitation or other actions related to the injured employee claims, and facilitates resolution of City cases before the Division of Workers' Compensation (DWC) and the Office of Injured Employee Counsel (OIEC).

The San Antonio Fire and Police Department uniformed personnel are subject to a Collective Bargaining Agreement and Chapter 143 of the Texas Local Government Code.

Roles & Responsibilities

Efficient and cost effective administration of the City-wide Workers' Compensation Program is the responsibility of all injured employees, supervisors, departmental workers' compensation representatives, department directors, and RM.

The Risk Management Division and the City departments are jointly responsible for implementing and completing their respective assignments relating to the workers' compensation and modified work assignment processes in a timely manner.

Employee

1. Employee notifies supervisor immediately of any accidental on-the-job injury, occupational illness or disease.
2. Speaks directly with the department supervisor on a regular basis and keep the supervisor apprised of any progress as it relates to your continued absence and injury.
3. Attend all medical appointments and obtains a "Texas Workers' Compensation Work Status Report" (DWC-73) to provide to the supervisor and HRS.
4. Employee reports outside employment to the TPA for the purpose of Income Benefits (TIBS). The employee is responsible for transportation to and from doctor's appointments.

Supervisors

1. Supervisor completes a “City of San Antonio Supervisor’s Report of Injury or Illness” (SRI), and provides the document to the HRS within the next business day from first knowledge of the injury or illness. **(Attachment A)**
2. Responsible for reporting protocol for injuries and illnesses occurring after the City’s normal business hours. **(Attachment B)**

Department Human Resources Specialist

The Human Resources Specialist (HRS) for each Department is responsible for the following:

- a. For completing a Employer’s First Report of Injury or Illness (DWC-1). **(Attachment C)**
- b. For processing the “City of San Antonio Vehicle Accident Report”, if applicable; **(Attachment E)**
- c. HRS informs Time and Attendance Specialist of the employee’s workers’ compensation absences as it pertains to the Administrative Directive 4.20, Family Medical Leave Act (FMLA).
- d. Prepares Supplemental Report of Injury (DWC 6) when the employee is placed out from work, returns to work, resigns or is terminated; **(Attachment F)**
- e. Notifies the Time and Attendance Specialist (TAS) paid administrative leave is granted to the employee requiring medical attention on the day the injury or illness occurs
- f. Coordinates with the TAS the process of administrative leave with pay is granted to employees with a qualified workers’ compensation injury and who have returned to work on a full-time basis for the purpose of attending medical appointments, including but not limited to doctor’s appointments or appointments for rehabilitative therapy;
- g. HRS notifies the TAS once the employee has reached MMI for the purpose of continued medical treatment and leave time.

Department Time and Attendance Specialist

The Time and Attendance Specialist (TAS) for the department will do the following:

- a. Process the “Employers’ Wage Statement” (DWC 3);
- b. Ensure accurate time tracking of administrative leave pay code titled WC01 is used for all workers’ compensation medical appointments.

Risk Management

1. Coordinate all City Workers’ Compensation claims with City departments, the TPA, and the DWC.

2. Act as liaison between the TPA and City departments.
3. Assist the TPA, City departments, and injured employees as necessary.
4. Conduct training sessions and updates on changes to the Workers' Compensation law, policies and procedures.
5. Provide claim status reports to Department Directors quarterly, or upon request.
6. Act as liaison between the TPA and City department when determining if a full time Park Police Officer was performing a "law enforcement function" causing injury.
7. Contact the Human Resources Representative and provide the time period for income benefits and the amount paid by the TPA for "Line of Duty.

Section II

Workers' Compensation Procedures

Injury Reporting

1. Civilian employees and uniformed personnel report his/her injury to their supervisor within 24 hours of its occurrence.
2. Supervisor completes the "Supervisor Report of Injury(SRI) form.
3. Supervisor forwards SRI document to Human Resources Specialist (HRS) within 24 hours of incident.
4. HRS will utilize the SRI to create a First Report of Injury (FROI) and enters the information into Third Party Administrator's (TPA) system within 24 hours of receipt of notice.
5. The TPA system generates a FROI and prompts notice of a claim to the TPA.
6. TPA claims supervisor assigns FROI to claims adjuster.
7. The adjuster begins the investigation of the claim, which includes contact with, supervisor, and employee.

Medical Treatment Process

1. Civilian and uniformed personnel have the right to seek medical attention with a physician of their choice.
2. When seeking medical attention the medical provider must be a healthcare provider who accepts workers' compensation patients.
3. All employees must hand carry the DWC 73 to their supervisor and/or HRS. **(Attachment G)**
4. All employees must hand carry the work status report, DWC 73 to their supervisor/and or HRS.

Administrative Leave for Medical Appointments

1. Leave approval is granted to an employee with a qualified Workers' Compensation injury and who has returned to work on a full-time basis for attending medical appointments, including but not limited to doctors' appointments or appointments for rehabilitative therapy.
2. Administrative leave applies to employees who have not reached Maximum Medical Improvement (MMI), and who provide documentation for the appointment from the

medical provider prior to the time of the appointment and documentation of the time the appointment ended.

3. Administrative Leave for appointments shall be limited to 2.5 hours per day, unless documentation provided by the employee indicates the duration of the appointment(s) was longer. Administrative leave shall not be approved without the appropriate documentation.
4. Qualified employees are strongly encouraged to schedule appointments during times best suited to meet the needs of their department.
5. The proper administrative leave payroll code is WC01. To ensure accurate time tracking, this payroll code must not be used for any other purpose.
6. Transportation to and from the physician's office and/or medical facility **may** be provided by the City at the time of the accident and on the same date as the accident.

Wage Statements

1. Human Resources Specialist notifies the TAS for a copy of the Employer's Wage Statement. **(Attachment H)**
2. The TAS enters the 13 weeks of earned wages into the TPA system within 24 hours of receipt of notice.
3. The wage statement is used by the claims adjuster for calculating income benefits.

Appeal Process

Under the provision of the Workers' Compensation Act an employee has the right to engage in the administrative appeals process as described in the statute. For details regarding an appeal contact the OIEC at 1-866-EZE-OIEC.

Time associated with the appeals process is not City paid time and must be conducted on the employee's own time.

Reporting Fraud

Fraud occurs when a person knowingly or intentionally conceals, misrepresents, and/or makes false statements.

Investigations often lead to prosecution and recovery of money gained through fraudulent schemes. Fraud can be committed by employers, employees, health care providers, attorneys, insurance agents, and others.

To report any possible fraudulent activity, contact the Texas Department of Insurance (TDI) Division of Workers' Compensation (DWC) at 1-888-327-8818.

Discipline

Violations of this manual may result in disciplinary action up to and including termination. In addition violations fall within the context of Municipal Civil Service Rule XVII.

Section III

TPA Procedures

Processing the First Report of Injury (FROI)

All new FROI's shall be reviewed by the TPA claims supervisor. Once determination is made on the initial type of the claim, either Record Only, Medical Only or Indemnity, the claim should be set up in the TPA claim system within one (1) business day from receipt. The claim is assigned to a claims adjuster for investigation.

Investigation and Determination

The TPA claims adjuster conducts an investigation of the claim and reviews all available evidence in determining the injury arose out of/or in the course and scope of employment.

The adjuster will request Recorded/Written Statements from the employee as part of the investigation a claim. When the claim investigation has been completed, the claims adjuster will make a determination of acceptance or denial of the claim within 15 days according to the Texas Workers' Compensation Act.

- Injured Employee: Contact will be made to inform the injured employee which claims adjuster is handling their claim, establish rapport, obtain statements, explain benefits and procedures, answer questions, and begin to develop an initial action plan.
- Lost Time Claims: The TPA claims adjuster will contact the injured employee within 24 hours of receipt of a lost time claim, or as soon as practicable. In instances where the claims adjuster efforts to contact the injured employee are unsuccessful, the claim file will be documented.
- Claim letters: All injured employees will receive a letter of claim acknowledgment. This letter confirms the TPA has received the claim and notifies the injured employee of the responsibility to notify the claims adjuster of any time lost from work.
- Information packet: The TPA adjusters will mail a copy of the FROI, Rights/Responsibilities, brochure and contact letter to the injured employee.
- Claimant contact: If the handling adjuster is unsuccessful in contacting a party (3-attempts, 3-business days), a letter shall be sent requesting a response from that party. RM staff should also be contacted for assistance.
- Claim denial: All denied claims will be sent to the employee's home address by certified mail. The HRS and RM will be notified by via email.

Medical Provider

The TPA claims adjuster will contact the primary care provider within 24 hours to confirm the history and mechanics of the injury, expected return-to-work date, what restrictions apply and for how long, medical treatment recommended, and other medical providers involved. Discussion will include the possibility of pre-existing or underlying conditions, prior treatment and a review of the treatment plan.

Employer

The TPA adjuster will contact RM or HRS to confirm and verify compensability, discuss questions concerning the claim and obtain information to help develop a plan of action.

- Claims involving San Antonio Police Officers need to arrange employee contact with the HRS.
- Note: The TPA is to contact RM if a new FROI is received with a cost center code beginning with ten (10). This applies to seasonal and temporary employees.
- RM will seek clarification with the Fiscal Administrator to verify the correct cost center code and will provide the information to the TPA.

Reserves

Reserves are to be set based on the estimated probable cost of the claim.

An initial reserve is to be setup within one (1) business day of receipt of the assignment for workers' compensation claim.

The claims adjuster and supervisor will address the adequacy of the loss and expense reserves at each diary date. The claims adjuster may contact RM for significant reserve adjustments as they occur or approval for significant changes by RM.

Check Register for Income/Medical Payments

The TPA will send a daily pre-pay check register via email to RM for approval.

1. The TPA will send the check register between 8 a.m. and 9 a.m. for approval on income benefit payments (TIBS). The TPA will send the register between 2 p.m. and 3 p.m. for approval on medical payments.
2. RM will review the check register to ensure timeliness of income benefits and medical payments comply with DWC guidelines/rules.
3. RM will reply by e-mail with the approval of the check register in order for the TPA to process the checks listed on the daily register.

DOCUMENTATION and CODING

Diary

The claim adjuster initial diary is addressed within twenty-one (21) days of claim assignment. At a minimum the file should reflect documentation regarding the initial contacts, indexing, medical treatment plan, reserves, excess exposure (if applicable), subrogation (if applicable), police reports (if applicable) and issuance of income benefit.

Plan of Action

An initial plan of action should be documented within fifteen (15) days of claim assignment and updated at a minimum of every thirty (30) days, for the first two years of the claim and every six (6) months thereafter.

File Documentation in TPA system

It is important that all claims files in the TPA system include sufficient information to allow an accurate portrayal of the claim progression. Listed are the following:

- Summary of all recorded statements
- Synopsis of all telephone conversations
- Summary of all medical/hospital reports/bills
- Comments regarding subrogation (if applicable)
- Details of Medical Disability Guidelines (MDA)
- Rationale for reserve levels and changes
- Claim file closure
- Receipt of vendors' bills and payments
- Receipt of employer forms (DWC 3, DWC 6)
- Summary of all significant correspondence
- Details of income benefits begins, ends or resumes
- Details of medical treatment with physicians
- Details of any administrative hearings (BRC, CCH, Appeals)
- Documentation of MMI/IR

Section IV

Excess Reporting Process

1. Claim assigned to adjuster for an investigation and determination of compensability.
2. Reserves are established based on the outcome of the investigation/compensability.
3. The TPA determines whether the claim meets the excess reporting criteria based on the Client Service Instructions, the City's contractual agreement, and the excess insurance policy. The following is a list of items which require immediate reporting:
 - Fatalities
 - Spinal cord injuries which do or are anticipated to result in paraplegia or quadriplegia
 - Brain damage
 - Third or second degree burns over 50% of the body
 - Amputation
 - Impairment of vision or hearing of 50% or more
 - Nerve damage causing paralysis or loss of sensation in the limb
 - Massive internal injuries affecting body organ(s)
 - Permanent total disability
 - Total incurred reaches 50%
4. The TPA:
 - a. Completes a Funds Management Request (FMR) form with information such as reserves, current payouts for medical and indemnity, any subrogation potentials, and description of incident.
 - b. Submits the FMR form to the Supervisor for review and approval prior to sending to the excess carrier.
 - c. Reviews the documents and approves for submission to excess carrier or makes recommendations prior to sending to the excess carrier.
 - d. Upon supervisor approval, the packet is sent to the appropriate excess carrier for set up and review.

- e. Uploads the documents in the VOS claim system and notates date the claim was initially reported to the excess carrier.
 - f. Shall send subsequent reports to the excess carrier every 6 months until the claim is closed or reporting is no longer required.
 - g. Shall send the City notifications via email each time a report is sent to the excess carrier.
5. RM shall track the notification in spreadsheet each time report sent to excess carrier.

Reimbursements from Excess Carrier

1. Excess carrier shall make reimbursement checks payable to City of San Antonio and mail to Risk Management Division (RM).
2. RM shall process check and send copy of check to TPA via email.
3. TPA shall credit reimbursement directly to the claim file.

Section V

Line of Duty for Uniformed Personnel

All Fire and Police Department uniformed personnel are subject to Chapter 143 of the Local Government Code and the Texas Workers' Compensation Act.

1. A uniformed employee placed out from work must exceed the seven (7) day waiting period to qualify for Temporary Income Benefits (TIBs).
2. The TPA pays TIBS no later than the seventh after the accrual date, which would be the 15th day.
3. TIBs are paid at a rate of 75% of the Average Weekly Wage (AWW) for weeks 1 to 13; on the 14th week a rate of 70% of the Average Weekly Wage begins.
4. The TPA pays the uniformed employee TIBs until he/she returns to work in some capacity.
5. RM processes a preliminary Line of Duty (LOD) spreadsheet every other Wednesday for the Fire Department and on Fridays for both Fire and Police. The line of duty report is processed on Fridays after the week of the scheduled payroll date for civilians
6. RM e-mails LOD report on designated days along with Line of Duty Notice. **(Attachment I)**
7. Refer to Line of Duty for Uniformed Personnel process. **(Attachment J)**

Section VI

Meet and Confer Agreement

The Meet and Confer is a process in which the City of San Antonio and the San Antonio Park Police Officers' Association enter into a written agreement.

“Police officers” or “peace officers,” means a full time employee not employed as an officer of the San Antonio Police Department and not governed by Chapter 143 of the Texas Local Government Code. **(Attachment K)**

The employees covered by the Meet and Confer are the following:

- Airport Police Corporal
- Airport Police Lieutenant
- Airport Police Officer
- Airport Police Sergeant
- Deputy City Marshall
- Deputy City Marshall Sergeant
- Park Police Lieutenant
- Park Police Officer
- Park Police Sergeant

An officer who sustains an illness/injury while working for the City must be performing a law enforcement function for the injury to be compensable under workers' compensation. In this case, the officer would be entitled to both workers' compensation weekly income benefits and the difference of the City's base pay for a 40 hour workweek as described in the Meet and Confer Agreement. The waiting period does not apply and is waived for employees listed above.

Steps for handling Meet and Confer injuries

1. The TPA shall contact Risk Management via email upon receiving the First Report of Injury/Illness (FROI) for each reported claim.
2. RM reviews the description of the event from the FROI and determines if the officer was performing a “law enforcement function” for the City.
3. If determined the officer was engaged in a “law enforcement function,” and lost time from work has occurred, the TPA will issue weekly income benefits.
4. RM will notify the Human Resources Representative (HR Rep) via email and provide the name of the employee, date of injury, indemnity amount paid, and the period covered per the TPA.
5. RM will send the financial information weekly to the HR Rep, until the officer is released to return to work and is no longer entitled to weekly income benefits.

6. If RM is unable to determine whether the officer was performing a “law enforcement function,” a copy of the FROI and other pertinent information about the injury/illness shall be provided to the City Attorney’s Office (CAO) for assistance.
7. If the CAO determines that the injury/illness does not constitute as a “law enforcement function,” the officer will only be entitled to workers’ compensation income benefits and not the base pay from the City.
8. The officer may appeal the decision to the Police Chief. The Police Chief has the final approval authority.

Section VII

Modified Work Assignment Program

1. The City of San Antonio has developed and implemented a program that will assist all employees with returning to work after an occupational or work related injury/illness.
2. The goal of the program is to ensure that all employees will be able to:
 - Return to their regular jobs and/or
 - Perform the job duties of a modified work assignment
3. The City will make a good faith effort to place an eligible employee in a modified work assignment, but is not obligated to create a modified work assignment for the employee.
4. Per A.D. 4.37, modified work assignments are temporary in nature and will not be made permanent: for civilian employees, modified duty will terminate at exhausting 180 days, reaching MMI or return to work full duty, whichever comes first. Uniformed personnel are not to exceed one (1) calendar year from the date of the assignment, unless otherwise stated in the Collective Bargaining Agreement.
5. An employee's pay classification shall not be affected while in a modified work assignment.
6. The City of San Antonio will offer a modified work assignment to employees who meet the following criteria:
 - Employee is full-time or part-time, uniform or non-uniform personnel for the City during the time of injury.
 - Employee must be suffering from the temporary effects of an injury, illness or condition that restricts the individual from performing the essential job functions of his/her position.
 - The employee must seek medical attention from a medical treatment facility, and provide documentation of treatment by a licensed physician.
 - The employee must not have violated any City policies.

Modified Work Assignment Process for Civilians

1. A Healthcare Provider or TPA shall submit to RM a copy of the DWC 73 via fax or by email.
2. RM will contact the (HRS)/supervisor to initiate modified work assignment for employees returning to work with restrictions.
3. HRS provides the department supervisor with a copy of the DWC 73.
4. The supervisor will review the restrictions and provide HRS with a list of job tasks for the employee to perform within their home department.
5. HRS will prepare the Bona-fide Offer (BFO) document within 24 hours of notification.
6. HRS submits BFO from the home department to RM via email or fax. **(Attachment L)**
7. If the home department is unable to accommodate the employee, RM will find a work assignment outside the home department, and prepare the BFO, forwarding a copy to the home department and the TPA.
8. RM will coordinate with HRS a BFO appointment, via email.
9. If RM or the HRS are unable to coordinate the BFO with employee by email or phone, a certified letter will be mailed to the employee with a copy of the BFO and DWC 73.
10. RM will meet with the injured employee at the Risk Management Division to extend the BFO and review the process.
11. HRS prepares a DWC 6 and submits to the TPA when the employee is to return to work with restrictions.
12. When an employee is released to return to work full duty, a DWC 6 is submitted to the TPA by the HRS.

Modified Work Assignment Process for SAFD

1. The TPA adjuster will send an email to the department and RM when their treating physician or a Designated Doctor (DD) has indicated the uniformed employee may return to work with restrictions. The DD has presumptive weight on the employee's return to work status.
2. The department will send an email notice to RM advising if the department may accommodate the employee (**Attachment M**).
3. RM will send the uniformed employee a certified mail letter to include the DWC 73 and the BFO outlining the details of the duties the employee will be performing.
4. The employee is to contact the department for further direction and assistance.
5. The department will advise both the adjuster and RM if the employee returns to work (RTW) as per the DD physician.

Checklist

Items to review with Employee by Risk Management

1. Verification of demographic information of employee
2. Purpose of Modified Work Assignment Program
3. Notification of A.D. 4.37 – Modified Work Assignment Administrative Directive.
4. Explanation of the Bona-fide Offer to include the duration of assignment
5. Employee’s responsibility of medical status changes
6. Provide overview of claim process to employee
7. Explain pharmacy vendor process if applicable
8. Explain process for doctor’s appointments if during work schedule
9. Employee will check off “**accept**” or “**not accept**” the work assignment offered. Risk Management will **provide the employee, supervisor, HRS and the TPA** a copy of the BFO via email.
10. Refer to the Modified Duty Work Assignment Process (**Attachment N**).

Section VIII

Definitions

Average Weekly Wage:

The wages an employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period).

Benefit:

A medical benefit, an income benefit, a death benefit, or a burial benefit based on a compensable injury.

Compensable Injury:

An injury that arises out of and in the course and scope of employment for which compensation is payable under the Texas Workers' Compensation Act.

Course and Scope:

An activity of any kind or character that has to do with and originates in the work, business, trade, or profession of the employer and that is performed by an employee while engaged in or about the furtherance of the affairs or business of the employer. The term includes an activity conducted on the premises of the employer or at other locations. The term does not include transportation to and from the place of employment unless:

- a. the transportation is furnished as a part of the contract of employment or is paid for by the employer;
- b. The means of the transportation are under the control of the employer; or
- c. The employee is directed in the employee's employment to proceed from one place to another place; or
- d. Travel by the employee in the furtherance of the affairs or business of the employer if the travel is also in furtherance of personal or private affairs of the employee unless: The travel to the place of occurrence of the injury would have been made even had there been no personal or private affairs of the employee to be furthered by the travel; and
- e. The travel would not have been made had there been no affairs or business of the employer to be furthered by the travel.

Disability:

Disability is the inability to obtain and retain employment at wages equivalent to the pre-injury wages.

DWC:

Division of Workers' Compensation, administers workers' compensation laws, resolves disputes over workers' compensation benefits and provides information and assistance to injured workers and others about the workers' compensation system.

Employer's First Report of Injury or Illness (DWC 1):

The DWC 1 provides information about the employee, employer, insurance and healthcare provider, if applicable; the supervisor includes the employee's employment and circumstances surrounding the injury or illness and forwards the completed form to the HRS

Employer's Wage Statement (DWC 3 form)

A form that provides the employee's average weekly wage to establish benefits due to the employee or a beneficiary based on gross wages earned 13 weeks preceding the date of injury.

FMLA:

Family Medical Leave Act entitlement of up to 12 weeks of paid or unpaid leave within a 12-month rolling period according to the CITY'S leave policies when an eligible employee is unable to work because of a serious health condition. The leave is normally continuous, intermittently or on a reduced schedule.

Impairment Income Benefits (IIBs):

Begins the day after the date the employee reaches maximum medical improvement (MMI) and continues at the rate of 3 weeks for each percentage point of impairment or the death of the employee, whichever is first.

Impairment:

Impairment is any anatomic functional abnormality or loss existing after maximum medical improvement that results from a compensable injury.

Impairment Rating:

The percentage of permanent impairment of the whole body resulting from a compensable injury as determined by a DWC authorized physician at the time when the employee reaches MMI.

Income Benefits:

A payment made to an employee for a compensable injury as prescribed by the DWC. The term does not include a medical benefit, death benefit, or burial benefit.

Injury:

Damage or harm to the physical structure of the body and a disease or infection naturally resulting from the damage or harm. The term includes an occupational disease.

Maximum Medical Improvement (MMI):

The earlier of the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated; or the expiration of 104 weeks from the date on which income benefits begin to accrue.

Medical Documentation:

Medical documentation includes any written communication provided by the health care provider as required by the Workers' compensation Program

Responsibility of the Employee:

It is the employee's responsibility to notify their supervisor about an injury or illness as soon as possible or within 24 hours. If at any time the injury causes absence from work, medical documentation employee's supervisor will need a copy. The injured employee must notify the department supervisor and/or Human Resources Specialist and the Risk Management Division after released to return to work (limited or regular duty). If the physician has assessed Maximum Medical Improvement (MMI), the injured worker will need to contact the Department Supervisor and/or Human Resources Specialist.

Similar Employee:

In determining an employee's average weekly wage absent a full 13 week wage history, a person with similar training, experience, nature of work, and the number of hours normally worked.

Supplemental Report of Injury (DWC 6):

A DWC 6 form is a form filled out by the HRS and sent to the TPA which illustrates changes in the employee's work status, changes in the employee's earnings as a result of the injury or when the employee resigns or is terminated.

Texas Workers' Compensation Act:

A Texas statute designed to provide legal and practical guidance regarding employee and employer rights concerning issues related to on the job injuries and related illnesses.

Texas Department of Insurance (TDI):

Texas Department of Insurance is a state agency that ensures proper delivery of benefits to injured workers, helps resolve disputes concerning injury claims filed by the injured worker, and provide a workplace health and safety services. TDI develops rules to administer the workers' compensation system and monitor the activities of the system participants. TDI does not pay benefits. Insurance companies or third-party administrators pay workers' compensation benefits.

Temporary Income Benefits (TIBS):

Compensation for lost wages due to the compensable injury during a period in which the employee has disability and has not reached maximum medical improvement.

Third Party Administrator (TPA):

The contract company handling adjustments of claims and support services for the City's Workers' Compensation Self Insured Program.

Treating Physician:

The physician is primarily responsible for the employee's health care for an injury. The employee is responsible for selecting doctor of choice.

Work Status Report (DWC 73):

The treating physician will complete the DWC 73 and determine the effective, and/or estimated expirations dates of work status and restrictions. The treating physician identifies the prevention of the employee returning to work and includes information about the claim/injury

Workers' Compensation:

A state regulated insurance program that provides covered employees with income and medical benefits if they sustain a work related injury

Section IX

ACRONYMS

AD	Administrative Directive
BFO	Bona-fide Offer
DWC 1	Employer's First Report of Injury or Illness (FROI)
DWC 3	Employer's Report of Wage Statement
DWC 6	Supplemental Report of Injury form (SRI)
DWC 73	Texas Workers' Compensation Work Status Report
ERBP	Employee's Relations Business Partner
HRS	Human Resources Specialist
IR	Impairment Rating
MMI	Maximum Medical Improvement
RM	Risk Management
RTW	Return to work
SRI	Supervisor's Report of Injury or Illness
TPA	Third Party Administrator

Section X

Attachments: Forms & Letter

Attachment A	Supervisor's Injury Investigation Report
Attachment B	After Hours Protocol
Attachment C	Employers First Report of Injury or Illness (DWC 1)
Attachment D	Workers' Compensation Claims Process
Attachment E	Vehicle Accident Report
Attachment F	Supplemental Report of Injury (DWC 6)
Attachment G	Texas Workers' Compensation Work Status Report (DWC 73)
Attachment H	Employer's Wage Statement (DWC 3)
Attachment I	Line of Duty Notice
Attachment J	Line of Duty for Uniformed Personnel Flowchart
Attachment K	Meet and Confer Agreement
Attachment L	Bona-fide Offer/Modified Work Assignment
Attachment M	Bona-fide Offer Certified letter
Attachment N	Modified Duty Work Assignment Process

ATTACHMENT A

	<h2 style="margin: 0;">CITY OF SAN ANTONIO</h2> <h3 style="margin: 0;">Supervisor Report of Injury or Illness</h3>		
MUST be completed and submitted within 24 hours of the incident <input type="checkbox"/> Initial <input type="checkbox"/> Amended Report #: _____ (Photos: <input type="checkbox"/> No <input type="checkbox"/> Yes By: _____)		DEPART CODE# (Required) _____	FOR RISK MGMT USE ONLY Prev <input type="checkbox"/> Non-Prev <input type="checkbox"/>
EMPLOYEE/PERSON INJURED (TO BE COMPLETED BY SUPERVISOR)			
1. Name (Last, First, M.I.):	2. SAP No.:	3. Sex: F <input type="checkbox"/> M <input type="checkbox"/>	21. Date of Injury (m/d/yy):
4. Social Security Number: XXX-XX-XXXX	5. Home Phone No.:	6. Date of Birth (m/d/yy):	22. Time of Injury: : am <input type="checkbox"/> pm <input type="checkbox"/>
7. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>	8. Injured Person Employee of COSA: YES <input type="checkbox"/> NO <input type="checkbox"/>		23. Date Lost Time Began (m/d/yy):
9. Race: White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>	10. Ethnicity: Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		24. Nature of Injury:
11. Mailing Address Street or P. O. Box City State Zip Code County			25. Part of Body Injured or Exposed:
12. Marital Status: Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			26. How and Why Injury/Illness Occurred:
13. Number of Dependent Children:	14. Spouse's Name:		27. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>
15. Name of Clinic/Hospital:			28. Worksite Location of Injury (stairs, dock, etc.):
16. Phone Number:			29. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Street or P. O. Box City
17. Mailing Address Street or P. O. Box City State Zip Code			30. Cause of Injury (fall, tool, machine, etc.):
18. Doctor's Name:			31. List Witnesses:
19. Phone Number:			32. Return to work date/or expected (m/d/yy):
20. Doctor's Mailing Address (Street or P. O. Box) City State Zip Code			33. Supervisor's Name:
			34. Date Reported (m/d/yy):
SUPERVISOR'S CORRECTIVE ACTION			
35. What factors contributed to the incident/injury? (List safety policies, protocol or practices not followed?)		36. What action will you take or recommend for preventing similar accidents?	
37. Preventable <input type="checkbox"/> Non-Preventable <input type="checkbox"/>		38. Supervisor's Name: Supervisor's Phone Number: (210) -	
39. Print Name and Title of Person Completing Report:		40. Name of Business: City of San Antonio	
41. Department Mailing Address and Telephone Number of Person Completed Report: Telephone (210) -		42. Business Location (if different from mailing address): 111 Soledad, Suite 1000	
City State Zip Code San Antonio TX		City State Zip Code San Antonio TX 78205	
43. Signature of Supervisor Completing Report:		44. Date:	
TO BE COMPLETED BY HUMAN RESOURCES SPECIALIST			
45. Date of Hire (m/d/yy):	46. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	47. Length of Service in Current Position Months ____ Years ____	48. Length of Service in Occupation Months ____ Years ____
49. Employee's Cost Center	50. Department / Division	51. Employee Payroll Classification Code	52. Occupation of Injured Worker
53. Rate of Pay at this job \$ ____ Hourly \$ ____ Weekly	54. Full Work Week is: ____ Hours ____ Days	55. Last Paycheck was: \$ ____ for ____ Hours or ____ Days	56. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>
57. Name of Person Submitting Report and Phone Number: (210) -			

SUPERVISOR TO SEND COPIES TO: DEPT. MGR.

HRS

SAFETY COORDINATOR

Email: RiskMgmt@sanantonio.gov

ATTACHMENT B

CITY OF SAN ANTONIO FINANCE DEPARTMENT – OFFICE OF RISK MANAGEMENT AFTER HOURS PROTOCOL

As part of Risk Management's commitment to meeting the needs of our employees, below are some frequently asked questions that may be of assistance outside the City's normal business hours.

Q: What happens if I'm injured outside the City's normal business hours?

A: If it is a severe injury requiring immediate medical treatment, go to the nearest emergency room or call 911. Notify your supervisor as soon as possible of the injury. The supervisor must report all work-related injuries directly to the City's third-party administrator, TRISTAR Risk Management, in one of three ways:

- o Phone: (210) 341-0815
- o Fax: (210) 404-0429
- o Email: Firstreport.cosa@tristargroup.net

Supervisor must also report all fatalities and/or major emergency events to Risk Management:

Art Mata, Safety Supervisor
(210) 219-4334
art.mata@sanantonio.gov

Q: How do I receive medical treatment if I'm injured?

A: An employee may seek medical treatment from any medical provider that accepts workers' compensation. Notify the medical provider that the treatment is for a work related injury/illness and that you are an employee with the City of San Antonio.

Q: If the physician prescribes medication, how do I get my prescription filled?

A: An Instant Activation pharmacy card is available from selected physicians and through TRISTAR Risk Management. If an instant activation card *is not* available, please provide the pharmacy the following information:

Modern Medical, Inc.
Phone: (800) 547-3330
VIN # 610011
PCN C37559077
Group # B466

CITY OF SAN ANTONIO
FINANCE DEPARTMENT – OFFICE OF RISK MANAGEMENT
AFTER HOURS PROTOCOL

Q: The physician told me I must be placed off work. What now?

A: The physician should provide you, and the City, with a form entitled Texas Workers' Compensation Work Status Report Form DWC 73. Notify your immediate supervisor that you have been placed off work and notify Risk Management the next business day.

Q: The physician has indicated that I may return to work with restrictions. What do I do?

A: The physician should provide you, and the City, with a form entitled Texas Workers' Compensation Work Status Report Form DWC 73. Hand carry the Work Status Report to your immediate supervisor for determination of job placement.

Q: What if I have an issue with my existing claim and need immediate attention.

A: Contact TRISTAR Risk Management at:

- o Karen Arbuckle (210) 383-3265
- o Delia Hernandez (210) 383-9535

Q: What if I am involved in an automobile accident outside of normal business hours.

A: Notify your supervisor of the accident. If the accident involves a fatality or severe property damage, contact Risk Management:

Art Mata, Safety Supervisor
(210) 219-4334
art.mata@sanantonio.gov

Q: What do I do if a City facility is severely damaged by a natural disaster (i.e., flood and/or fire)?

A: Immediately contact Risk Management:

Mark Triesch, Risk Analyst
(210) 326-8501
mark.triesh@sanantonio.gov

ATTACHMENT C

Mail this form to:
 STATE OFFICE OF RISK MANAGEMENT
 P. O. Box 13777
 Austin, Texas 78711

Please read instruction sheet CAREFULLY,
 giving special attention to items marked
 with an asterisk (*).

CLAIM #	[REDACTED]
---------	------------

SORM CLAIM #	[REDACTED]
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EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) [REDACTED]		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y) [REDACTED]		16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>		17. Date Lost Time Began (m-d-y) [REDACTED]	
3. Social Security Number [REDACTED]		4. Home Phone () [REDACTED]		5. Date of Birth (m-d-y) [REDACTED]		18. Nature of Injury*		19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/> [REDACTED]									
7. Employee Telephone # [REDACTED]				8. Block no longer used					
9. Mailing Address Street or P.O. Box [REDACTED]									
City [REDACTED]		State [REDACTED]		Zip Code [REDACTED]		County [REDACTED]			
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>									
11. Number of Dependent Children [REDACTED]				12. Spouse's Name [REDACTED]					
13. Doctor's Name [REDACTED]				Telephone # [REDACTED]					
14. Doctor's Mailing Address (Street or P.O. Box) [REDACTED]									
City [REDACTED]		State [REDACTED]		Zip Code [REDACTED]					
21. Was employee doing his/her regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>				22. Worksite Location of Injury (stairs, dock, etc.)* [REDACTED]					
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site [REDACTED]									
City [REDACTED]		State [REDACTED]		Zip Code [REDACTED]					
24. Cause of Injury (fall, tool, machine, etc.)* [REDACTED]									
25. List Witnesses (Name, Telephone #) [REDACTED]									
26. Return to work date (m-d-y) [REDACTED]			27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>			28. Supervisor's Name [REDACTED]		29. Date Reported (m-d-y) [REDACTED]	

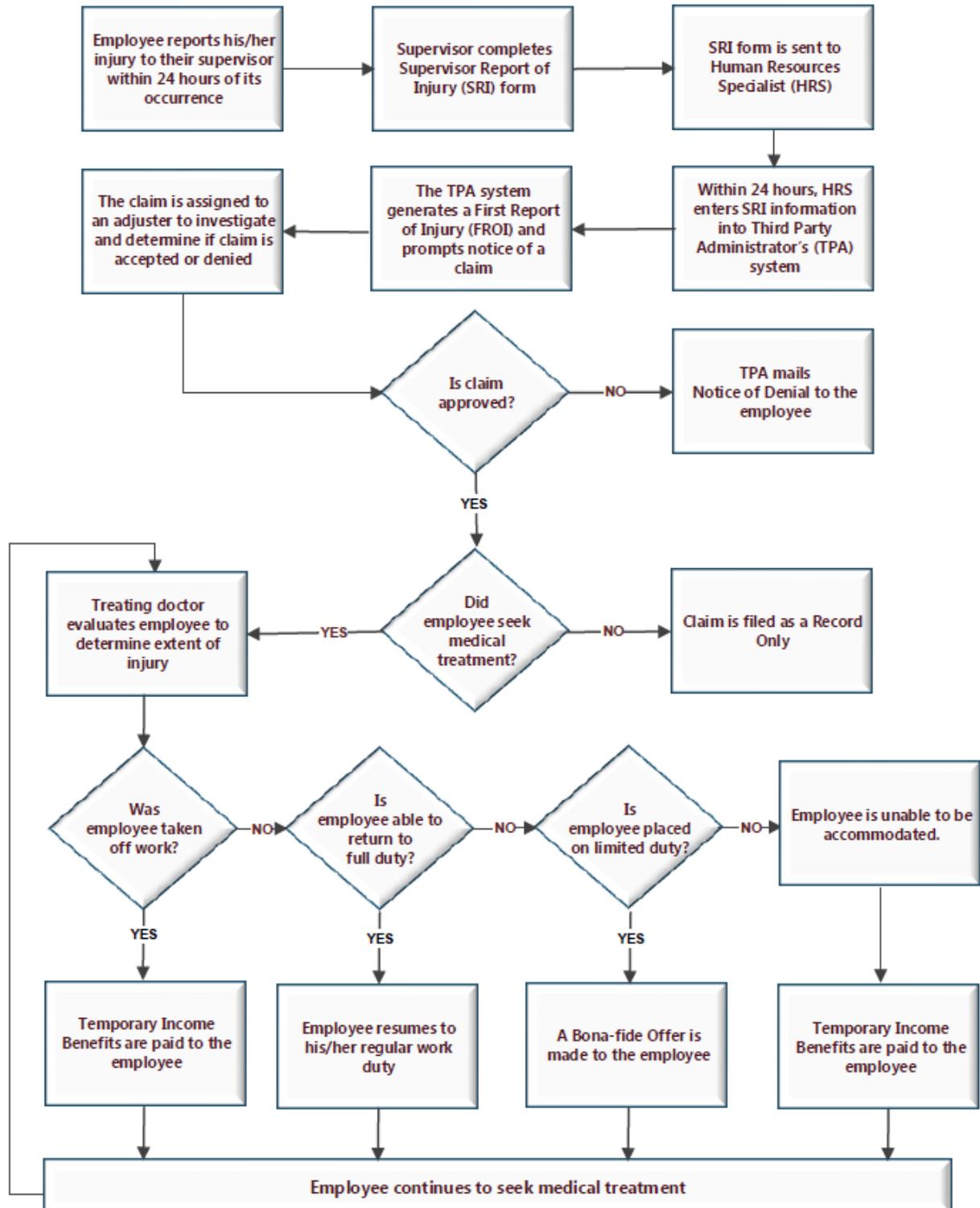
30. Date of Hire (m-d-y) [REDACTED]		31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. Length of Service in Current Position Years [REDACTED] Months [REDACTED]		33. Length of Service in Occupation Years [REDACTED] Months [REDACTED]	
34. State Payroll Classification Code [REDACTED]				35. Occupation of Injured Worker [REDACTED]			
36. Rate of Pay at this Job \$ [REDACTED] Hourly \$ [REDACTED] Weekly \$ [REDACTED] Monthly		37. Full Work Week is: [REDACTED] Hours [REDACTED] Days		38. Last Paycheck was: \$ [REDACTED]		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>	

40. Name and Title of Person Completing Form [REDACTED] Claims Coordinator				41. Name of Agency [REDACTED]			
42. Agency Mailing Address and Telephone Number Street or P.O. Box [REDACTED] Telephone () [REDACTED]				43. Agency Location Code [REDACTED] / [REDACTED] / [REDACTED]			
City [REDACTED]		State [REDACTED]		Zip Code [REDACTED]		Name of Location: [REDACTED]	
44. Federal Tax Identification Number [REDACTED]		45. Primary North American Industrial Classification System Sector Code (NAICS) (2 digits) [REDACTED]		46. Specific NAICS Code [REDACTED]		47. Comptroller Agency Code [REDACTED]	
48. Workers' Compensation Insurance Company State Office of Risk Management				49. Policy Number TXSTATEPOL001			
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>				52. Number of Hours of Sick/Annual Leave Credited to Employee or Date of Injury [REDACTED]			
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) [REDACTED]							



ATTACHMENT D

Workers' Compensation Claims Process



08/01/14

ATTACHMENT E

	CITY OF SAN ANTONIO Supervisor Report of Vehicle Accident				<input type="button" value="Print Form"/>			
	MUST be completed and submitted within 24 hours of the accident. <input type="checkbox"/> Initial <input type="checkbox"/> Amended Report #: _____ (Photos: <input type="checkbox"/> No <input type="checkbox"/> Yes By: _____)				DEPARTMENT CODE # (Required) _____		RISK MGMT USE ONLY Prev ___ Non-Prev ___	
CITY DRIVER INFORMATION: (NOTE ITEM 44 thru 104 must be filled out at the scene of the accident)								
1. NAME OF DRIVER:		2. AGE:	3. SAP NUMBER:	4. WAS EMPLOYEE INJURED: <input type="checkbox"/> YES <input type="checkbox"/> NO		5. TELEPHONE NUMBER:		
6. HOME STREET ADDRESS:		7. CITY:		8. STATE:	9. ZIP CODE:	10. DRIVER'S LICENSE (STATE / NUMBER): /		
CITY VEHICLE/EQUIPMENT INFORMATION:								
11. YEAR MODEL:	12. MAKE OF VEHICLE:	13. MODEL OF VEHICLE:	14. VEHICLE TYPE:	15. VEHICLE LICENSE NUMBER:		16. COSA VEHICLE NUMBER:		
17. VEHICLE IDENTIFICATION NUMBER:			18. WAS VEHICLE ON COSA BUSINESS: <input type="checkbox"/> YES <input type="checkbox"/> NO		20. AUTHORIZED COSA BUSINESS: <input type="checkbox"/> YES <input type="checkbox"/> NO			
21. COSA INSURANCE		22. STREET ADDRESS:		23. CITY:		24. STATE:	25. ZIP CODE:	
26. PURPOSE FOR WHICH VEHICLE WAS BEING USED:			27. NATURE AND EXTENT OF DAMAGE:					
TIME AND PLACE OF ACCIDENT:								
28. DATE OF ACCIDENT:	29. TIME OF ACCIDENT: <input type="checkbox"/> AM <input type="checkbox"/> PM		30. CITY / STATE ACCIDENT HAPPENED IN: /		31. REPORTED TO POLICE: <input type="checkbox"/> YES <input type="checkbox"/> NO	32. POLICE DEPARTMENT REPORTED TO:		
33. POLICE CASE NUMBER:	34. ROAD CONDITIONS: <input type="checkbox"/> Dry <input type="checkbox"/> Wet <input type="checkbox"/> Icy <input type="checkbox"/> Standing Water			35. WEATHER CONDITIONS (check all that apply): <input type="checkbox"/> Clear <input type="checkbox"/> Cloudy <input type="checkbox"/> Raining <input type="checkbox"/> Windy <input type="checkbox"/> Foggy <input type="checkbox"/> Freezing $\leq 32^{\circ}$ <input type="checkbox"/> Cold $>32^{\circ}$ - $<60^{\circ}$				
36. SPEED AT TIME OF ACCIDENT: MPH	37. LOCATION OF ACCIDENT (STREET, INTERSECTION, ETC) (GO TO BLOCK 110):							
38. NAME OF PLACE TOWED TO:		39. STREET ADDRESS:		40. CITY:	41. STATE:	42. ZIP CODE:	43. PHONE NUMBER:	
IF ANOTHER VEHICLE WAS INVOLVED COMPLETE QUESTIONS 44 thru 120								
44. NAME OF OTHER DRIVER:		45. STREET ADDRESS:		46. CITY:	47. STATE:	48. ZIP CODE:	49. DRIVER'S LICENSE (STATE / NUMBER): /	
50. MAKE OF VEHICLE:	51. MODEL OF VEHICLE:	52. YEAR MODEL:	53. LICENSE PLATE NUMBER:		54. VEHICLE INSURED: <input type="checkbox"/> YES <input type="checkbox"/> NO			
55. NAME OF INSURANCE COMPANY:		56. STREET ADDRESS:		57. CITY:		58. STATE:	59. ZIP CODE:	60. PHONE NUMBER:
61. OWNER NAME:		62. STREET ADDRESS:		63. CITY:	64. STATE:	65. ZIP CODE:	66. DRIVER'S LICENSE (STATE / NUMBER): /	
67. EXPLAIN NATURE AND EXTENT OF VEHICLE OR PROPERTY DAMAGE: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>								
NAMES AND ADDRESSES OF OCCUPANT AND WITNESSES:) (Use additional paper if needed and attach to this report) <input type="checkbox"/> Not applicable								
68. NAME OF 1 ST OCCUPANT OF CITY VEHICLE:		69. STREET ADDRESS:		70. CITY:	71. STATE:	72. ZIP CODE:	73. PHONE NUMBER:	
74. NAME OF 2 ND OCCUPANT OF CITY VEHICLE:		75. STREET ADDRESS:		76. CITY:	77. STATE:	78. ZIP CODE:	79. PHONE NUMBER:	
80. NAME OF 1 ST OCCUPANT OF OTHER VEHICLE:		81. STREET ADDRESS:		82. CITY:	83. STATE:	84. ZIP CODE:	85. PHONE NUMBER:	
86. NAME OF 2 ND OCCUPANT OF OTHER VEHICLE:		87. STREET ADDRESS:		88. CITY:	89. STATE:	90. ZIP CODE:	91. PHONE NUMBER:	
92. NAME OF 1 ST WITNESS (IMPORTANT):		93. STREET ADDRESS:		94. CITY:	95. STATE:	96. ZIP CODE:	97. PHONE NUMBER:	
98. NAME OF 2 ND WITNESS (IMPORTANT):		99. STREET ADDRESS:		100. CITY:	101. STATE:	102. ZIP CODE:	103. PHONE NUMBER:	
Risk Management Form - 2 (03/25/15)				Page 1 OF 2				

ATTACHMENT F



CLAIM #	
Carrier #	

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. <input type="checkbox"/>	a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
<input type="checkbox"/>	b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
<input type="checkbox"/>	c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
<input type="checkbox"/>	d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits) xxx-xx-	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes <input type="checkbox"/> no <input type="checkbox"/> If yes, the date of the 8 th day (mm/dd/yyyy) _____		
18. Date of most recent RTW _____ <input type="checkbox"/> Full duty, full pay <input type="checkbox"/> Limited duty, full pay <input type="checkbox"/> Limited duty, reduced pay	19. Has the injured worker resigned, been terminated or died? yes <input type="checkbox"/> no <input type="checkbox"/> date of resignation _____ date of termination _____ date of death _____	
	19a. Reason for resignation/termination _____	
	19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week		21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____
Indicated hours are: <input type="checkbox"/> Increase from pre-injury <input type="checkbox"/> Same as pre-injury <input type="checkbox"/> Decrease from pre-injury		Indicated wages are: <input type="checkbox"/> Increase from pre-injury wage <input type="checkbox"/> Same a pre-injury wage <input type="checkbox"/> Decrease from pre-injury wage

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker (If no longer working for the employer where injury occurred.)

Signature and Title of person completing this form _____

Date _____



ATTACHMENT G

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 Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.



Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION		5. Doctor's Name and Degree <input style="width: 100%;" type="text"/>	(for transmission purposes only)	Date Being Sent <input style="width: 100%;" type="text"/>
1. Injured Employee's Name <input style="width: 100%;" type="text"/>		6. Clinic/Facility Name <input style="width: 100%;" type="text"/>		9. Employer's Name <input style="width: 100%;" type="text"/>
2. Date of Injury <input style="width: 100%;" type="text"/>	3. Social Security Number (last 4) XXX-XX- <input style="width: 100%;" type="text"/>	7. Clinic/Facility/Doctor Phone & Fax <input style="width: 100%;" type="text"/>		10. Employer's Fax # or Email Address (if known) <input style="width: 100%;" type="text"/>
4. Employee's Description of Injury/Accident <input style="width: 100%;" type="text"/>		8. Clinic/Facility/Doctor Address (street address) <input style="width: 100%;" type="text"/>		11. Insurance Carrier <input style="width: 100%;" type="text"/>
		City <input style="width: 20%;" type="text"/> State <input style="width: 20%;" type="text"/> Zip <input style="width: 20%;" type="text"/>		12. Carrier's Fax # or Email Address (if known) <input style="width: 100%;" type="text"/>

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:	
<input type="checkbox"/> (a) will allow the employee to return to work as of <input style="width: 100px;" type="text"/> (date) <u>without restrictions</u> .	
<input type="checkbox"/> (b) will allow the employee to return to work as of <input style="width: 100px;" type="text"/> (date) <u>with the restrictions</u> identified in PART III, which are expected to last through <input style="width: 100px;" type="text"/> (date).	
<input type="checkbox"/> (c) has prevented and still prevents the employee from returning to work as of <input style="width: 100px;" type="text"/> (date) and is expected to continue through <input style="width: 100px;" type="text"/> (date).	
The following describes how this injury prevents the employee from returning to work: <input style="width: 100%; height: 20px;" type="text"/>	

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)					
14. POSTURE RESTRICTIONS (if any):		17. MOTION RESTRICTIONS (if any):		19. MISC. RESTRICTIONS (if any):	
Max Hours per day: 0 2 4 6 8	Other <input style="width: 100px;" type="text"/>	Max Hours per day: 0 2 4 6 8	Other <input style="width: 100px;" type="text"/>	<input type="checkbox"/> Max hours per day of work: <input style="width: 50px;" type="text"/>	
Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Sit/Stretch breaks of <input style="width: 20px;" type="text"/> per <input style="width: 20px;" type="text"/>	
Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Must wear splint/cast at work	
Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Must use crutches at all times	
Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> No driving/operating heavy equipment	
Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Can only drive automatic transmission	
Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> No work / <input style="width: 20px;" type="text"/> hours/day work:	
Other: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> in extreme hot/cold environments	
15. RESTRICTIONS SPECIFIC TO (if applicable):		18. LIFT/CARRY RESTRICTIONS (if any):		20. MEDICATION RESTRICTIONS (if any):	
<input type="checkbox"/> Left Hand/Wrist <input type="checkbox"/> Left Leg <input type="checkbox"/> Right Hand/Wrist <input type="checkbox"/> Right Leg <input type="checkbox"/> Left Arm <input type="checkbox"/> Back <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Foot/Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Right Foot/Ankle	Other: <input style="width: 100px;" type="text"/>	<input type="checkbox"/> May not lift/carry objects more than <input style="width: 50px;" type="text"/> lbs. for more than <input style="width: 50px;" type="text"/> hours per day <input type="checkbox"/> May not perform any lifting/carrying		<input type="checkbox"/> Must keep <input style="width: 20px;" type="text"/> elevated <input type="checkbox"/> clean & dry <input type="checkbox"/> No skin contact with: <input style="width: 100px;" type="text"/> <input type="checkbox"/> Dressing changes necessary at work <input type="checkbox"/> No running	
16. OTHER RESTRICTIONS (if any): <input style="width: 100%; height: 20px;" type="text"/>		Other: <input style="width: 100%; height: 20px;" type="text"/>		<input type="checkbox"/> Must take prescription medication(s) <input type="checkbox"/> Advised to take over-the-counter meds <input type="checkbox"/> Medication may make drowsy (possible safety/driving issues)	

* 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.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION					
21. Work Injury Diagnosis Information: <input style="width: 100%; height: 40px;" type="text"/>		22. Expected Follow-up Services Include:			
		<input type="checkbox"/> Evaluation by the treating doctor on <input style="width: 100px;" type="text"/> (date) at <input style="width: 20px;" type="text"/> : <input style="width: 20px;" type="text"/> am/pm			
		<input type="checkbox"/> Referral to/Consult with <input style="width: 100px;" type="text"/> on <input style="width: 100px;" type="text"/> (date) at <input style="width: 20px;" type="text"/> : <input style="width: 20px;" type="text"/> am/pm			
		<input type="checkbox"/> Physical medicine <input style="width: 20px;" type="text"/> X per week for <input style="width: 20px;" type="text"/> weeks starting on <input style="width: 100px;" type="text"/> (date) at <input style="width: 20px;" type="text"/> : <input style="width: 20px;" type="text"/> am/pm			
		<input type="checkbox"/> Special studies (list): <input style="width: 100px;" type="text"/> on <input style="width: 100px;" type="text"/> (date) at <input style="width: 20px;" type="text"/> : <input style="width: 20px;" type="text"/> am/pm			
		<input type="checkbox"/> None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.			
Date / Time of Visit <input style="width: 100%;" type="text"/>	EMPLOYEE'S SIGNATURE <input style="width: 100%;" type="text"/>	DOCTOR'S SIGNATURE <input style="width: 100%;" type="text"/>	Visit Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up	Role of Doctor: <input type="checkbox"/> Designated doctor <input type="checkbox"/> Treating doctor <input type="checkbox"/> Referral doctor <input type="checkbox"/> Consulting doctor	<input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> DWC-selected RME <input type="checkbox"/> Other doctor
Discharge Time <input style="width: 100%;" type="text"/>					



ATTACHMENT H

Send to workers' compensation carrier:

 (Name and fax number of carrier)



CLAIM # _____
 CARRIER'S CLAIM # _____

Initial Amended **EMPLOYER'S WAGE STATEMENT (DWC Form-003)**

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

- (A) the employee's eighth day of disability;
- (B) the date the employer is notified that the employee is entitled to income benefits;
- (C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at <http://www.tdi.texas.gov/wc/rules/>

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.): _____	Employer's Business Name: _____
Employee's Mailing Address (Street or P.O. Box): _____	Employer's Mailing Address (Street or P.O. Box): _____
City: _____ State: _____ ZIP Code: _____	City: _____ State: _____ ZIP Code: _____
Social Security Number: xxx-xx-_____	Federal Tax I.D. Number: _____
Date of Hire: _____ Date of Injury: _____	Name and Phone # of Person Providing Wage Information: _____

- As of today's date, the employee is not back at work. **OR**
 The employee returned to work on _____ and is working:
 without restriction. **OR**
 with restrictions and is earning wages of \$ _____ per week/month (circle one).

NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-8) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

<input type="checkbox"/> Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. | <input type="checkbox"/> Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.
<input type="checkbox"/> Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.
<input type="checkbox"/> Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan. | <input type="checkbox"/> Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.
<input type="checkbox"/> Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
<input type="checkbox"/> Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it. |
|---|--|--|

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:
 The Injured Employee **OR** A Similar Employee (**NOTE** - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee **AND** who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at <http://www.tdi.texas.gov/wc/rules/>



WAGE INFORMATION INSTRUCTIONS

Employee Name: _____ Social Security #: _____ Date of Injury: _____

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														
# HOURS WORKED:														TOTALS
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid to allow the employee to purchase the benefits.

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/Cleaning																		
Clothing/Uniforms																		
Lodging/Housing/																		
Food/Meals																		
Vehicle/Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§562.021 and 562.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.



ATTACHMENT I

LINE OF DUTY NOTICE

To: Beth Taylor, SAFD
Lucia Puente, SAFD
Rachel M Guerra, SAFD
Annette Vicenico, SAPD
Carol Hinojosa, SAPD

Attached is the Line of Duty (LOD) Report for the period of 08/08/15 to 08/22/15.

To avoid overpayments, notify the TPA and Risk Management when a uniformed employee is resigning, retiring or terminated from the City. Please complete and email all forms to both of these email addresses:

- TPA - FirstReport.COSA@tristargroup.net
- Risk Management - HRWorkers.Comp@sanantonio.gov

The forms to be submitted are:

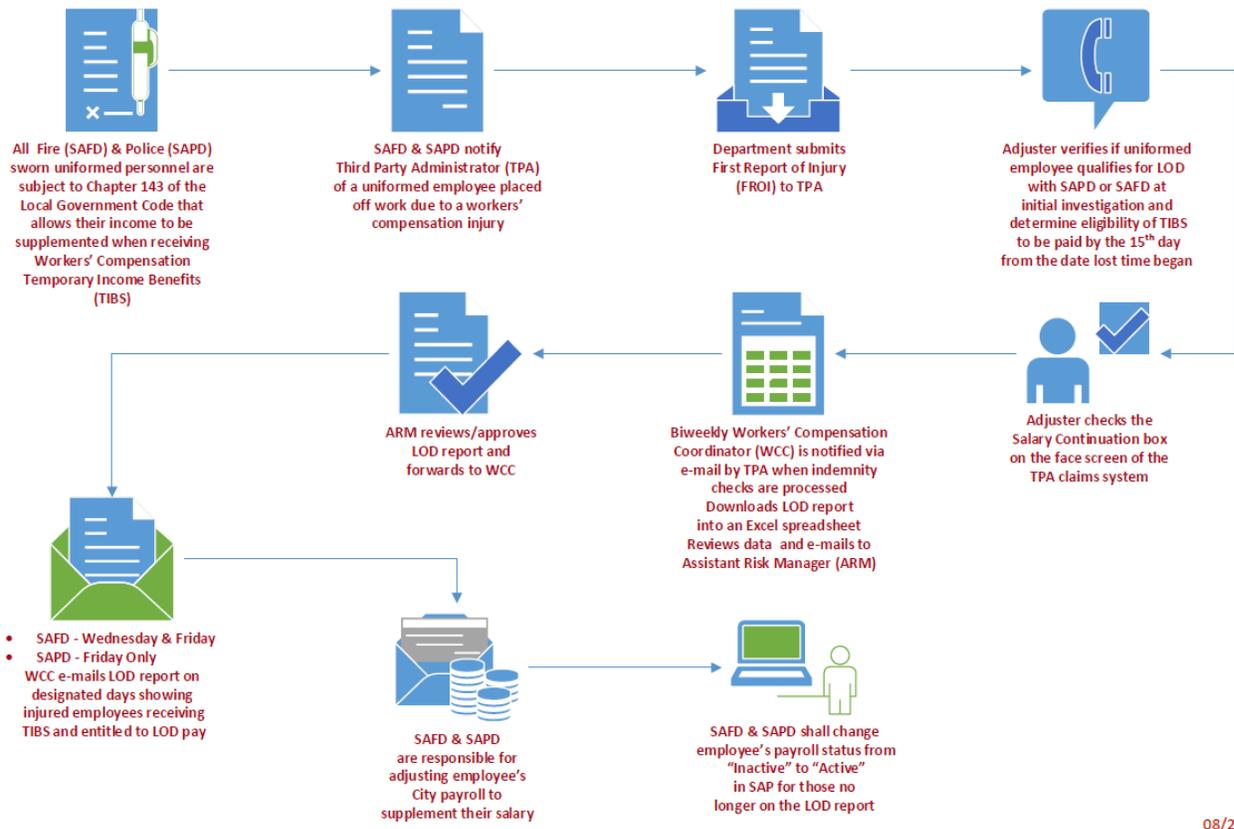
- DWC 6 – Supplemental Report of Injury
- DWC 3 – Employer's Wage Statement
 - a. Page 1 – Check the box AMENDED
 - b. Page 2 – Review Nonpecuniary Wage Information
 - i. Select YES – if the employee will continue to received benefits
 - ii. Select No – if the employee will not receive benefits and enter the date benefits were suspended

As a reminder, if a uniform employee is not listed on the attached LOD report, the department must change the employee's payroll status from "INACTIVE" to "ACTIVE" in SAP. This will avoid duplicate payments and payroll issues with the uniformed employee's pay.

CC: Joni James, Finance

ATTACHMENT J

LINE OF DUTY FOR UNIFORMED PERSONNEL



08/21/15

ATTACHMENT K

THE CITY OF SAN ANTONIO, TEXAS

AND

THE SAN ANTONIO PARK POLICE OFFICERS' ASSOCIATION

MEET AND CONFER

AGREEMENT

OCTOBER 1, 2013

TO

SEPTEMBER 30, 2015

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MEET & CONFER AGREEMENT

STATE OF TEXAS §
 §
COUNTY OF BEXAR §

This Agreement is entered into by and between the City of San Antonio, a Texas home-rule municipal corporation ("City"), acting by and through its City Manager, pursuant to Ordinance No. _____ passed and approved on the _____ day of _____, 2013 and the San Antonio Park Police Officers' Association ("Association"), both of which may be referred to herein collectively as the "Parties."

WHEREAS, Senate Bill 772 amended Chapter 142 of the Texas Local Government Code, Subchapter B, to allow municipal police officers who are not covered by collective bargaining to seek the right to meet and confer about the terms and conditions of their employment; and

WHEREAS, the law, as amended by Senate Bill 772, took effect September 1, 2007; and

WHEREAS, pursuant to this state law, the meet and confer process was required to be initiated by presentation of a petition from a police officers' association, signed by the majority of all police officers, with certain exceptions, that requests recognition of the association as the sole and exclusive bargaining agent for all covered police officers employed by the municipality; and

WHEREAS, the process was initiated on September 5, 2007, when such a petition was submitted to the City Council of the City of San Antonio, by the San Antonio Park Police Officers' Association, seeking recognition as the sole and exclusive bargaining agent for all covered police officers; and

WHEREAS, the City of San Antonio granted recognition of the San Antonio Park Police Officers' Association by vote of the San Antonio City Council on October 4, 2007, without holding and election by the voters of the City of San Antonio; and

WHEREAS, the City of San Antonio and the San Antonio Park Police Officers' Association engaged in meet and confer deliberations, and reached an agreement on the terms set forth in this agreement; and

NOW THEREFORE, the Parties hereto severally and collectively agree, and by the execution hereof are bound, to the mutual obligations herein contained and to the performance and accomplishment of the tasks hereinafter described.

ARTICLE 1
DEFINITIONS

1.1 “Police officer,” “officer,” or “peace officer” means:

- (a) a full-time employee of the City of San Antonio,
- (b) who is required as a condition of such employment to be commissioned by the Texas Commission on Law Enforcement Officer Standards and Education,
- (c) is not covered by a collective bargaining agreement adopted under Chapter 174 of the Texas Local Government Code,
- (d) is not employed as an officer of the San Antonio Police Department,
- (e) is not governed by Chapter 143 of the Texas Local Government Code, and
- (f) is not a Department’s Chief or Captain.

1.2 A “law-enforcement function” is an activity entrusted by law to persons identified in Article 2.12 of the Texas Code Criminal Procedure, and should be considered co-extensive with any of the duties set forth in Article 2.13 of the Texas Code of Criminal Procedure and activities directly related to the performance of those duties. A “law-enforcement function” accomplishes an identifiable Article 2.13 duty or power; it is not an activity done to qualify, enable, or make an officer ready to perform such duty or power should the need to do so arise in the future. “Law enforcement function” includes patrolling. For officers whose assigned duties include providing law-enforcement training to other officers, “law-enforcement function” includes the provision of such training.

1.3 “Base pay” means an officer’s pay exclusive of any and all incentives, enhancements, and/or additions. For instance, an employee’s annual “base pay” under the City of San Antonio Step Pay Plan is the amount stated in the table entry corresponding to the employee’s grade and step. Incentives, enhancements, and/or additions include, but are not limited to, incentive pay, certification pay, shift differential, and/or any other pay that increases an officer’s compensation above base pay.

1.4 “Regular hourly rate of pay” means the hourly pay rate used to calculate overtime owed, if any, under the Fair Labor Standards Act, for the seven-day work period during which the overtime was worked.

1.5 “Work period” means a regularly repeating seven-day period beginning at 12:00 a.m. each Saturday and ending the instant before the next work period begins.

1.6 “Chief” is the person holding the office of the Chief of an officer’s Department, or, if an officer does not serve under the Chief, the Director of the municipal department for which the officer works.

1.7 “Association” means the San Antonio Park Police Officers’ Association as the sole and exclusive bargaining agent for all officers.

ARTICLE 2

EFFECTIVE DATE AND TERM

This Agreement shall take effect on: (1) the date on which it is ratified by the Association by conducting a secret ballot election at which the majority of the police officers to be covered by the Agreement vote in favor of ratifying this Agreement, or (2) the effective date of the ordinance approving this Agreement by majority vote of the City Council of the City, whichever is later, and shall remain in effect until September 30, 2015. The provisions of this Agreement are effective only during the term of the agreement and dissolve upon its expiration.

ARTICLE 3

GENERAL CONTRACTUAL PROVISIONS

3.1 Beneficiaries: The terms and conditions of this Agreement shall benefit only a "police officer," "officer," or "peace officer," as those terms are defined herein.

3.2 Effect on Employee-Management Committee: The Association acknowledges and agrees that the Employment-Management Committee process provided for in Ordinance No. 99630 has been superseded by a Meet and Confer process for all officers represented by the Association. In lieu of that Committee process, the City agrees to meet with the Association at least twice per fiscal year in order to seek input into administrative directives or other policies and procedures affecting the covered officers. These meetings will be of an informal nature and are not intended to be an extension of the Meet and Confer process, nor affect the local control of the City over wages, hours and other conditions of employment of its employees. The Association shall continue to have a seat at Employment-Management Committee meetings, but shall be excluded from discussion on matters to which the Meet and Confer process applies, as determined by the City's Director of Human Resources.

3.3 Discretionary Powers: Authority and/or discretion granted by this Agreement to the Chief may be exercised by a person designated by the Chief.

3.4 Scope and Preemption: During its term and to the extent of any conflict, this Agreement preempts all contrary state statutes, local ordinances, executive orders, civil service provisions, or rules adopted by the head of the law enforcement agency or municipality or by a division or agent of the municipality, such as a personnel board or a civil service commission. All regulations, standard operating procedures, administrative directives, general manual provisions, past practices and/or customs of any officer's department concerning matters addressed in Articles 4, 5, 8, and 9 which require more or less of, or place qualitatively different obligations on the City and/or an officer than provided in Articles 4, 5, 8 and 9, are inconsistent with those Articles and are hereby superseded while those Articles are effective under this Agreement. Officers are not entitled to any employment benefits, conditions, protections, or privileges provided for in Chapter 143 of the Texas Local Government Code. No collective bargaining agreement, or part thereof, between the City and the San Antonio Police Officers Association

applies to or covers officers. Officers are not eligible to participate in or benefit from the health insurance plan provided to San Antonio Police Department officers. Officers are not eligible to participate in or benefit from the Fire and Police Retiree Health Care Fund. Officers are not eligible to take promotional examinations for SAPD classifications, including but not limited to Detective/Investigator, Sergeant, Lieutenant, or Captain.

ARTICLE 4

WAGES AND BENEFITS

4.1 Pay Plan: The City's Step Pay Plan has been fully implemented for all officers covered by this Agreement.

4.2 COLA: Officers will receive the Council approved Cost of living Adjustment ("COLA") for Fiscal Year 2014 and Fiscal Year 2015. Pay Plan steps applicable to the City's workforce, added to the Pay Plan or created by City Council, which become effective during the term of this Agreement shall apply to officers as they apply to the balance of the workforce.

4.3 Protection of Pay: An officer who leaves service as an officer covered by this Agreement in order to enter the San Antonio Police Department Academy shall be paid the greater of the officer's Pay Plan pay, fixed as of the date the officer leaves service as an officer covered by this Agreement, or full pay as a San Antonio Police Department Cadet or San Antonio Police Department Officer, for 18 months after leaving service as an officer covered by this Agreement, so long as the officer remains in continuous service as a San Antonio Police Department Cadet or San Antonio Police Department Officer.

4.4 Hours of Work: All Officers shall be paid overtime for hours, or parts thereof, worked in excess of 40 in a work period. The overtime rate shall be calculated under the Fair Standards Act (FLSA) overtime computation principles, notwithstanding that the FLSA does not require payment for overtime until an officer has worked 43 hours in a pay period.

4.5 Non-Exempt: Park police lieutenants and airport police lieutenants shall be considered non-exempt employees.

4.6 Honorably Retired Officers: Each officer who honorably retires after 20 years (or more) service as a law enforcement officer licensed in the State of Texas, at least 15 of which have been served as an officer who meets the definition in Section 1.1, above, shall be given his or her service handgun and badge at no charge and reasonable access to the firing range used by the officer's Department.

4.7 K9 Officers: The pay and working conditions for Airport Police K9 officers in San Antonio Airport Police Standard Operating Procedures Field Operations, Procedure 916(A), shall remain in effect during the term of this Agreement.

ARTICLE 5

CERTIFICATION PAY

All officers who attain certification by the Texas Commission on Law Enforcement shall receive monthly certification pay corresponding to the officer's certification level, in the following amount:

	Current Certification Pay
Basic Peace Officer	\$50.00
Intermediate Peace Officer	\$75.00
Advanced Peace Officer	\$125.00
Master Peace Officer	\$175

ARTICLE 6

ADMINISTRATIVE DISCIPLINE

6.1 Administrative Reassignment in Lieu of Suspension Without Pay:

(a) If a peace officer is arrested or indicted for a felony or charged with a Class A or B misdemeanor, the Chief or the Chief's designee may temporarily reassign the officer to administrative duty. The officer shall be notified in writing of the reassignment.

(b) Officers who have been reassigned under this Article are prohibited from riding in any marked police vehicle or performing any job task that requires him/her to exercise arrest authority. This reassignment is in no way intended to reflect an opinion on the merits of the arrest or indictment or complaint.

(c) Conviction of a felony constitutes grounds for immediate termination. Conviction of a Class A or B misdemeanor constitutes grounds for discipline up to and including termination, within the sole discretion of the Chief.

6.2 Disciplinary Action:

(a) Officers are subject to disciplinary procedures in the General Manual or Police and Procedure Manual governing their department.

(b) Each officer who receives notice of proposed or contemplated-discipline consisting of suspension without pay or termination shall be afforded an in-person meeting with the Chief, in which the officer is provided a reasonable opportunity to offer argument of mitigation or innocence of the charges and may be represented by counsel, if the officer provides written notice to the Chief's office within five (5) business days (Saturdays, Sundays and City holidays are not business days) of the officer's receipt of the notice of proposed or contemplated

discipline. The Chief will provide the officer at least two opportunities for the in-person meeting, during the Chief's regular business hours, to occur in the ten business days following notice by the officer. No officer who has timely provided notice under this article may be assessed suspension without pay or termination unless the officer has been offered the in-person meeting with the Chief in compliance with this provision.

6.3 Officer Bill of Rights:

1. Counsel.

(a) Officers are entitled to representation by counsel during the disciplinary appeal process.

(b) Officers are entitled to representation by counsel during the pre-disciplinary meeting with the Chief, as provided in Section 6.2 (b).

(c) An officer who is the subject of an administrative investigation that may result in suspension or termination may have counsel present during the interview, but counsel may not participate in the interview except to assert any rights afforded to the officer, and only in a manner which does not impair the ability of the investigator to conduct the interview and obtain information directly from the officer. Delay of an investigative interview, including delay due to the unavailability of counsel, impairs the ability of the investigator to conduct the interview and obtain information directly from the officer. However, if the investigator determines that his ability to conduct the interview is impaired due to the unavailability of counsel, the investigator shall notify and obtain the approval of his or her supervisor prior to continuing the investigative interview outside the presence of the officer's counsel. If, during the course of the interview, the investigator determines the officer's counsel is disrupting and impeding the interview, the investigator may exclude counsel from the remainder of the interview.

2. Use of Information Obtained from Subject of Internal Administrative Investigation. An officer who is the subject of an internal administrative investigation that may result in suspension or termination may be ordered to provide responsive information as part of the investigation. The responsive information provided by the officer shall be subject to the privileges against use in a criminal proceeding set forth in *Garrity*.

3. Statement by Officer under Investigation. An officer who is the subject of an internal administrative investigation that may result in suspension or termination and who provides a written statement may obtain a copy of the written statement. If the officer gives an oral statement in the course of such an investigation, and if the oral statement is recorded or transcribed, the officer may obtain a copy of the statement.

4. Complaints Against Officers. The provisions of the Texas Government Code, Title 6, Chapter 614, Subchapter B, regarding complaints against officers, apply to officers covered by this Agreement. In addition, an officer who is the subject of an internal administrative investigation that may result in suspension or termination shall be informed of the general nature of any alleged misconduct and the policy and/or procedures that are alleged to have been violated prior to being interrogated or asked to otherwise respond as part of the investigation.

5. **Polygraph Examinations.** The provisions of the Texas Government Code, Title 6, Chapter 614, Subchapter E, regarding polygraph examinations, apply to officers covered by this Agreement.

ARTICLE 7

LINE OF DUTY ILLNESS OR INJURY LEAVE OF ABSENCE

7.1 Leave of Absence: The City shall provide a leave of absence to a peace officer who incurs or sustains a illness or injury while performing a law-enforcement function for the City of San Antonio. This leave of absence shall not be available to a peace officer who suffers employment-related injuries or illnesses that do not occur while performing a law-enforcement function.

7.2 Duration:

(a) The leave of absence shall be for a period commensurate with the nature of the qualifying illness or injury and shall terminate when the peace officer is first able to return to work, either in full or modified-duty status.

(b) No officer is entitled to leave under this Article after the first anniversary of the date of the qualifying injury or illness. On-duty exacerbations or aggravations of qualifying illnesses or injuries shall be treated as if sustained on the date of the original qualifying illness or injury.

7.3 Benefit:

(a) During the leave of absence, the officer is entitled to receive as weekly pay the difference between (i) the officer's worker's compensation weekly income benefit and (ii) the base pay the officer would have received for a 40-hour workweek.

(b) When a benefit is due under part (a) of this section for less than a full week of leave, the peace officer shall be paid in the same ratio as the number of hours of leave of absence taken by the officer in the corresponding week bears to 40 hours.

(c) A benefit due under this article shall commence to be paid within three weeks of the date that the third party administrator for worker's compensation notifies the City that this injury qualifies as a work related injury.

7.4 Return to Duty: After returning from a leave of absence under this Article, a peace officer shall resume the same or equivalent duties held by the officer before the leave commenced. However, nothing in this section shall be construed to entitle any reinstated employee to any right, benefit or position of employment other than any right, benefit, or position to which the employee would have been entitled had the leave not been taken.

7.5 Review by the Chief: The Chief may review whether circumstances surrounding an injury sustained on patrol or during training were incurred while performing a law-enforcement function for the City of San Antonio.

ARTICLE 8
COURT PAY

8.1 When the City requires and/or the prosecuting authority in a criminal prosecution subpoenas a police officer to testify in a proceeding before any venue listed in section 8.7 during hours when the officer is not regularly scheduled to be on duty, the City shall credit the officer a minimum of three (3) hours of work or the actual time spent by the officer in compulsory attendance at the proceeding, whichever is greater.

8.2 The City shall credit an officer for actual time spent appearing live at a hearing before the City of San Antonio's Civil Service Commission, or participating, at the request of the City or the prosecuting authority in a criminal prosecution, in a telephone hearing before any venue listed in section 8.7, during hours when the officer is not regularly scheduled to be on duty.

8.3 Hours credited under this Article shall be paid at the officer's regular hourly rate of pay, unless the total number of hours worked and credited to the officer during the work period exceeds 40, in which case all hours over 40 shall be paid at 1.5 times the officer's regular hourly rate of pay.

8.4 The Chief of an officer's department may elect to credit the officer with compensatory time in lieu of payment, in conformity with Section VII of Administrative Directive 4.48. Compensatory time credits shall be awarded hour-for-hour unless the total number of hours worked or credited to the officer during the work period exceeds 40, in which case 1.5 hours of compensatory time shall be credited for each hour exceeding 40.

8.5 This Article shall not obligate the City to pay or credit compensatory time to an officer (a) called or subpoenaed to testify in any proceeding unrelated to matters observed or occurring in the course and scope of the officer's employment for the City, or (b) called or subpoenaed to testify by a person who is not the City or the prosecuting authority in the proceeding to which the officer was subpoenaed.

8.6 The Chief is vested with discretion to credit an officer with compensatory time for travel to and from a proceeding for which the officer is entitled to credit under this Article if the proceeding is outside Bexar County. It is intended that this discretion should be liberally exercised in favor of the officer. Compensatory time under this Article shall be credited in the manner described in the second sentence of Section 8.4.

8.7 List of applicable venues:

- (a) Federal and State District Courts, including pre-trial conferences with the prosecuting authority
- (b) County Courts at Law
- (c) Grand Juries
- (d) Justice of the Peace Courts
- (e) Municipal Courts

(f) Hearings of the Texas Alcoholic Beverage Commission

(g) Administrative License Revocation Hearings

(h) Pardon and Parole Hearings

8.8 When the City or the prosecuting authority in a criminal prosecution places an officer on standby to be available to appear and give testimony at a proceeding before any venue listed in section 8.7, during hours when the officer is not regularly scheduled to be on duty, and the officer is not summoned to physically appear at the venue, the officer shall be credited with one (1) hour of work. An officer who receives a credit under any other section of this Article is ineligible to receive a credit under this section for the same day.

8.9 Stacking and Multiple Appearances.

(a) This Article shall be construed to prevent stacking or doubling of time credits. Therefore, whenever an officer is required to appear at more than one proceeding under conditions described in section 8.1 of this Article, and the officer's initial reporting times at each proceeding fall within a three hour time-span, the total time credited to the officer shall be computed as if the officer had appeared at only one proceeding. The time credit shall be calculated by counting all hours spent in compulsory attendance between the officer's earliest reporting time and the officer's final dismissal from any of the proceedings.

(b) Notwithstanding section 8.9(a), an officer may receive two separate credits under this Article when:

i) the officer attends a proceeding under conditions described in section 8.1 of this Article,

ii) is required to attend a second proceeding under conditions described in section 8.1 of this Article, and

iii) the officer's initial reporting time for the second proceeding is more than three hours later than the time the officer is required to report for the first proceeding.

(c) Under no circumstance shall an officer receive credit under this Article for more than:

i) six (6) hours, or

ii) the actual time spent in compulsory attendance between the officer's earliest reporting time and the officer's final release from any and all of the proceedings at which the officer is required to appear on a single day, whichever is greater.

8.10 An officer is not regularly scheduled to be on duty if:

(a) the City of San Antonio requires and/or the prosecuting authority in a criminal prosecution subpoenas a police officer to testify in a proceeding before any venue listed in section 8.7,

(b) the officer is scheduled to be on leave at the time of the proceeding, and

(c) the officer had requested the leave before receiving notice, in any form, of the date and time the officer's compulsory attendance at the proceeding would be required.

8.11 All regulations, standard operating procedures, administrative directives, general manual provisions, past practices and/or customs of any officer's department which are inconsistent with this Article (that is, those which require more or less of, or place qualitatively different obligations on the City and/or an officer) are hereby superseded.

ARTICLE 9

UNIFORM CLOTHING: ISSUANCE AND MAINTENANCE ALLOWANCE

9.1 The City shall provide the following uniforms and equipment to each newly hired officer:

- (a) Five (5) regulation uniform shirts with official, regulation insignia. The officer may choose how many of the shirts have long and/or short sleeves;
- (b) Five (5) regulation uniform trousers;
- (c) One (1) regulation uniform jacket with official, regulation insignia;
- (d) One (1) set of regulation uniform rainwear;
- (e) One (1) regulation uniform hat, including hat band, strap and hat badge;
- (f) One (1) leather equipment-and-accessory belt of the type required to be worn by officers of the officer's Department, and;
- (g) One (1) set of leather accessories of the type required to be worn by officers of the officer's department.
- (h) One (1) National Institute of Justice ("NIJ"), U.S. Department of Justice compliant ballistic vest less than five (5) years old.

9.2 Except as set forth in Section 9.3, each officer shall maintain, repair, and replace his or her uniforms, equipment, and accessories. When an officer purchases replacement uniform shirts, the City shall provide official, regulation insignia. In order to ensure that each officer satisfies this obligation, each eligible officer shall be paid a quarterly allowance of \$210.00 at the beginning of each quarter of the fiscal year that begins October 1, 2013, and \$320 at the beginning of each quarter of the fiscal year that begins October 1, 2014. An officer is eligible for the quarterly allowance on the earlier of 1) the officer's first anniversary of law-enforcement employment with the City, or 2) the first anniversary of the date the items specified in Section 9.1 are furnished.

9.3 The City shall repair or replace an officer's damaged or destroyed uniforms, equipment, and/or accessories, of the type described in Paragraph 9.1, if the Chief determines that the damage or destruction warrants replacement and occurred while the officer performed duties required by the officer's employment with the City of San Antonio. This provision is intended to be the exception rather than the rule. The City shall not be required to repair or replace uniforms, equipment, and/or accessories damaged or destroyed by age or normal wear and tear. The Chief's

determination in this respect is final and binding, subject only to appeal to the Director of Human Resources, whose decision in this respect is not subject to further review.

9.4 An officer, upon separation from law-enforcement employment with the City, shall surrender all of his or her uniforms and equipment of the type described in section 9.1 of this Article to the Chief.

9.5 This Article does not apply to or affect the City's or a Department's policies and practices concerning weapons, which are not part of an officer's uniform clothing.

9.6 All regulations, standard operating procedures, general manual provisions, administrative directives, past practices and/or customs of any officer's department which are inconsistent with this Article (that is, those which require more or less of, or place qualitatively different obligations on the City and/or an officer) are hereby superseded.

ARTICLE 10

REDUCTION IN FORCE

For purposes of applying Rule XIX, § 1.b. of the Municipal Civil Service Rules of the City of San Antonio to officers, "longevity" means the length of the officer's continuous service as a full-time sworn law enforcement officer who would be covered by this Agreement.

ARTICLE 11

SEVERABILITY

If any clause or provision of this Agreement is held invalid, illegal or unenforceable under present or future federal, state or local laws, including but not limited to the City Charter, City Code, or ordinances of the City of San Antonio, Texas, then and in that event it is the intention of the parties hereto that such invalidity, illegality or unenforceability shall not affect any other clause or provision hereof and that the remainder of this Agreement shall be construed as if such invalid, illegal or unenforceable clause or provision was never contained herein.

ARTICLE 12

LAW APPLICABLE

12.1 THIS AGREEMENT SHALL BE CONSTRUED UNDER AND IN ACCORDANCE WITH THE LAWS OF THE STATE OF TEXAS AND ALL OBLIGATIONS OF THE PARTIES CREATED HEREUNDER ARE PERFORMABLE IN BEXAR COUNTY, TEXAS.

12.2 Any legal action or proceeding brought or maintained, directly or indirectly, as a result of this Agreement shall be heard and determined in the City of San Antonio, Bexar County, Texas.

CITY OF SAN ANTONIO

Erik J. Walsh
(Signature)

Printed
Name: Erik J. Walsh

Title: Deputy City Manager

Date: 9/30/13

Approved as to Form:

[Signature]
City Attorney

SAN ANTONIO PARK POLICE
OFFICERS' ASSOCIATION

Brady L. Wise
(Signature)

Printed
Name: BRADY LEE WISE

Title: PRESIDENT, SAPPOA

Date: 9/23/13

ATTACHMENT L

CITY OF SAN ANTONIO FINANCE DEPARTMENT/RISK MANAGEMENT DIVISION BONA-FIDE OFFER/MODIFIED WORK ASSIGNMENT

The City of San Antonio is in receipt of the Work Status Report (DWC 73) dated _____ from Dr. _____ relating to your current work related injury and your ability to work. A copy of the DWC 73 is enclosed for your records. The City has identified a modified duty position for you, and hereby extends to you a bona-fide offer of employment pursuant to TWCC Rule 129.6

This assignment is within your capabilities as described on the Work Status Report. You will only be assigned tasks consistent with your physical abilities, skills and knowledge. If any training is required to do this assignment, it will be provided.

EMPLOYEE:	DOI:
SOC. SEC. NO.: xxx-xx-	COST CENTER #:
	SAP#:
Effective Date:	From: To:
Modified Work Assignment Duties:	
Restrictions:	See Attached DWC 73
Work Hours:	
Work Days:	
Days Off:	
Dept. & Work Location:	
Supervisor/Phone No.:	
Wage Information/Hourly:	\$

If you accept this offer, please indicate by signing and dating your name below and returning this to the undersigned.

If you do not accept this offer, your Temporary Income Benefits (TIBs) may be suspended. If we do not receive this back from you within five (5) days of receipt, the City will assume you have rejected this offer.

_____ I have read and understand the requirements of the position and accept the position.

_____ I have read and understand the requirements of the position but do NOT accept the position.

Employee's Signature

Date Signed

Workers' Compensation Risk Analyst

Date Signed

ATTACHMENT M



City of San Antonio
Finance Department
Risk Management Division
Workers' Compensation
(210) 207-2015 Office
(210) 207-4064 FAX No.

111 Soledad, Suite 1000
Riverview Towers Building
San Antonio, TX 78205

Cert:

Date:

RE: Bona-Fide Offer of Employment

Dear:

After reviewing your Work Status Report (DWC 73) provided by the workers' compensation physician, we are pleased to offer you the following modified work assignment. Please refer to the enclosed DWC 73.

A bona-fide offer is also enclosed for your review outlining the modified duty work assignment. This assignment is completely within the limitations described by the medical physician. This offer will remain open for five (5) days of receipt of this letter. Please review and sign the bona-fide offer and return via e-mail, hand carry, or facsimile as listed above.

If we do not hear from you within this timeframe, we will assume that you have refused this offer which may impact your Temporary Income Benefits (TIBs).

We look forward to your return. If you have any questions, please do not hesitate to contact me.

Sincerely,

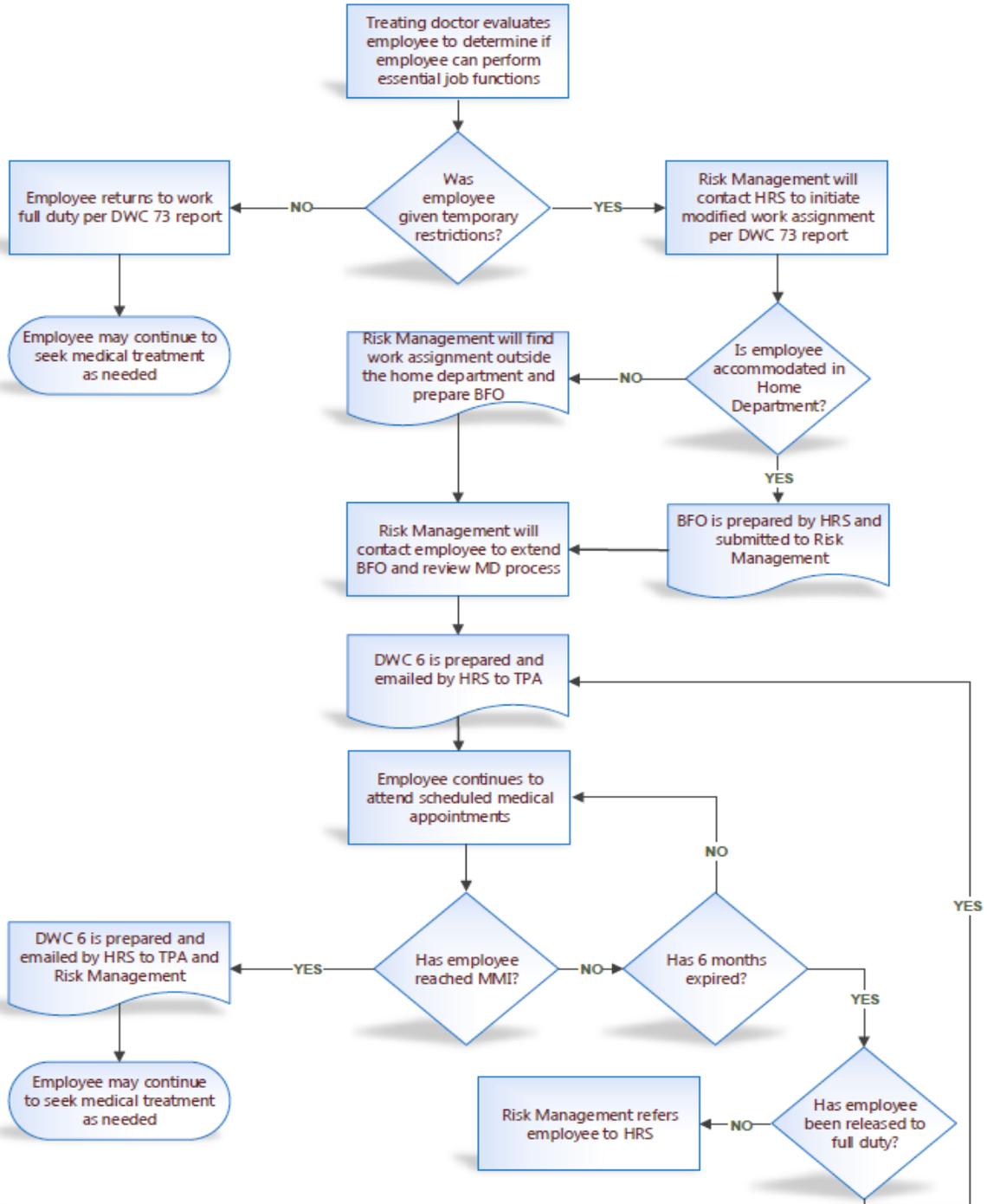
Risk Analyst

Phone: (210) 207-2015

Attachments: DWC 73, Work
ment

ATTACHMENT N

Modified Duty Work Assignment Process



6/1/2016