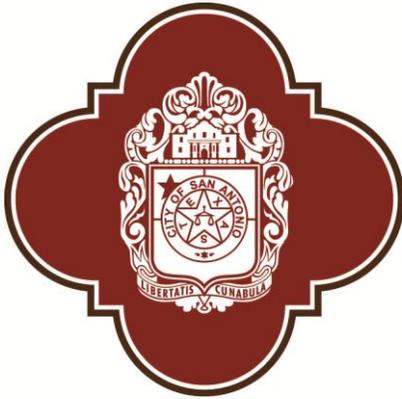


# CITY OF SAN ANTONIO



<b>Administrative Directive</b>	<b>4.84 Workers' Compensation Program</b>
<b>Procedural Guidelines</b>	Guidelines to ensure consistent processing and administration of the City Workers' Compensation Program
<b>Department/Division</b>	Finance Department / Risk Management Division
<b>Effective Date</b>	January, 31 2006
<b>Revision Dates</b>	March 26, 2012, March 1, 2016
<b>Review Date</b>	January 8, 2016
<b>Project Manager</b>	Assistant Finance Director / Risk Manager

## Purpose

The purpose of this administrative directive (AD) is to provide guidelines to ensure accurate and efficient processing of Workers' Compensation claims as required by the Texas Workers' Compensation Act and to provide guidelines to assist employees who sustain compensable on the job injuries.

## Policy

The City of San Antonio (COSA) became subject to the Texas Workers' Compensation Act in July 1974. The Act requires the COSA 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 injuries resulting in death. The Texas Workers' Compensation Act applies to all COSA employees. However, Chapter 143.073 of the Local Government Code (Line of Duty Pay) augments this administrative directive.

The Risk Management Division of the Finance Department ("Risk Management") processes 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 COSA cases before the Division of Workers' Compensation (DWC) and the Office of Injured Employee Counsel (OIEC).

In accordance with Administrative Directive 4.20, Family Medical Leave Act (FMLA), workers' compensation and FMLA absences run concurrently. Additional reference material is available in the Workers' Compensation and Modified Work Procedures Manual.

## Policy Applies To

- |  |  |
|--|--|
| <input type="checkbox"/> External & Internal Applicants  | <input checked="" type="checkbox"/> Current Temporary Employees      |
| <input checked="" type="checkbox"/> Current Full-Time Employees                                | <input type="checkbox"/> Current Volunteers                          |
| <input checked="" type="checkbox"/> Current Part-Time Employees                                | <input checked="" type="checkbox"/> Current Grant-Funded Employees   |
| <input checked="" type="checkbox"/> Current Paid and Unpaid Interns                            | <input checked="" type="checkbox"/> Police and Fire Academy Trainees |
| <input checked="" type="checkbox"/> Uniformed Employees Under Collective Bargaining Agreements |  |

<b>Definitions</b>	
<b>Average Weekly Wage</b>	The average weekly 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).
<b>Benefit</b>	A medical benefit, an income benefit, a death benefit, or a burial benefit based on a compensable injury.
<b>Compensable Injury</b>	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.
<b>Course and Scope</b>	<p>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:</p> <ol style="list-style-type: none"> <li>a. the transportation is furnished as a part of the contract of employment or is paid for by the employer;</li> <li>b. the means of the transportation are under the control of the employer; or</li> <li>c. the employee is directed in the employee's employment to proceed from one place to another place; or</li> <li>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: <ul style="list-style-type: none"> <li>• 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</li> <li>• the travel would not have been made had there been no affairs or business of the employer to be furthered by the travel.</li> </ul> </li> </ol>
<b>Disability</b>	The inability, because of a compensable on the job injury or illness, to obtain and retain employment at wages equivalent to the pre-injury wages.
<b>Employer's Wage Statement</b>	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.
<b>FMLA</b>	Family Medical Leave Act entitlement of up to 12 weeks of paid or unpaid leave within a 12-month rolling period according to the COSA's leave policies when an eligible employee is unable to work because of a serious health condition. The leave is normally continuous, but may also be taken intermittently or on a reduced schedule.
<b>IIBs (Impairment Income Benefits)</b>	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.

<b>Income Benefits</b>	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.
<b>Injury</b>	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.
<b>MMI (Maximum Medical Improvement)</b>	An injured employee reaches a state where his or her condition cannot be improved with any further medical care or when the injured employee has fully recovered from the injury, but the healing process has plateau.
<b>Texas Workers' Compensation Act</b>	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.
<b>TIBs (Temporary Income Benefits)</b>	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.
<b>TPA (Third Party Administrator)</b>	The contracted company that handles the adjustment of claims and support services for COSA's Workers' Compensation Self Insured Program.
<b>Treating Physician</b>	The physician primarily responsible for the employee's health care for an injury. This medical doctor is chosen by the employee.
<b>Policy Guidelines</b>	
<b>Benefits</b>	<p>1. Medical Benefits:</p> <p>An injured employee is entitled to medical and hospital services which are reasonably required at the time of the injury and as may be necessary to cure or relieve the effects resulting from the injury. All treating physician, hospital, prescriptions and allied bills are paid directly by the COSA through the TPA. An employee's initial choice of doctor is considered to be his or her treating physician. If an employee wants to later change treating physicians, approval must be obtained through the DWC.</p> <p>2. Temporary Income Benefits (TIBs):</p> <p>A civilian employee may qualify for TIBs if the employee has a disability and has not attained Maximum Medical Improvement (MMI). Payment of TIBs for time lost from work due to a compensable on-the-job injury is made directly to the employee on a weekly basis from the TPA. The COSA has voluntarily established the practice of paying accelerated TIBs to injured, non-uniformed civilian employees who have been removed from duty by a treating physician and are eligible for weekly compensation benefits. All eligible non-uniformed civilian employees shall receive TIBs at the rate of 75% of their average weekly wage for the first 13 weeks of disability. Beginning on the 14<sup>th</sup> week of TIBs, the employee will receive 70% of their average weekly wage.</p>

<p><b>Benefits (Cont.)</b></p>	<p>Benefits for uniformed members of the San Antonio Fire Department and the San Antonio Police Departments are subject to Chapter 143 of the Local Government Code and the Texas Workers' Compensation Act</p> <p>TIBs continue until the employee reaches MMI, but in no event later than 104 weeks after income benefits have been initiated. There are maximum and minimum rates for TIBs which are updated yearly by the DWC.</p> <p>3. Impairment Income Benefits (IIBs):</p> <p>Once a physician has indicated that an employee has reached MMI, the employee may be entitled to IIBs. IIBs payments are paid at 70% of the employee's average weekly wage and continue at the rate of three (3) weeks for each percentage point of the impairment rating until the total IIB payment is made or upon the death of the employee, whichever occurs first. IIBs are paid in accordance with statutory law found in the Act. There are maximum and minimum rates for IIBs which are updated yearly by the Division.</p> <p>4. Modified Work Assignment Program for Work-related Illnesses or Injuries:</p> <p>The COSA's Modified Work Assignment Program for Work-related Illnesses or Injuries is available to temporarily place employees in limited-duty work while recovering from compensable injuries that arise out of and in the course of employment which prevents full participation at work. A modified work assignment shall be made within the employee's home department if available. If a modified work assignment is not available in the home department, then the employee may be assigned to another department. An employee shall not remain on modified-duty for more than six (6) months per work related injury/illness and/or occupational disease, returned to work full duty, or has been determined by a physician to be in a state of MMI. Refer to Administrative Directive 4.37, Modified Work Assignment Program for Work-related Illnesses or Injuries.</p>
<p><b>Termination of Benefits</b></p>	<p>An employee's eligibility for income benefits terminates on the expiration of 401 weeks after the date of injury. For employees with an occupational disease, the employee's eligibility for TIBs terminates on the expiration of 401 weeks after the date on which benefits began to accrue.</p> <p>An employee may lose Workers' Compensation benefits under the following conditions:</p> <ol style="list-style-type: none"> <li>a. If an employee fails or refuses to comply with or violates the treating physician's instructions or advice regarding treatment of the injured condition.</li> <li>b. If an employee refuses to accept a bona fide offer of a modified duty position or refuses to perform the modified duties within the employee's physical capacity and for which the employee is qualified to do, or has been instructed on how to perform the modified duty assignment.</li> </ol>

<b>Termination of Benefits (Cont.)</b>	c. If an employee falsifies or misrepresents the injured condition or physical capacity or disability while receiving workers' compensation benefits.
<b>Roles &amp; Responsibilities</b>	
<p>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 the Department of Finance Risk Management Division.</p> <p>Risk Management and the employee's home department are mutually responsible for implementing and completing their respective assignments in a timely manner.</p>	
<b>Employee</b>	<ol style="list-style-type: none"> <li>1. Notify your supervisor within 24 hours of any accidental on-the-job injury, occupational illness or disease.</li> <li>2. Speak directly with your department supervisor on a regular basis and keep them advised of any progress as it relates to your continued absence and injury.</li> <li>3. Attend all medical appointments and obtain a "Work Status Report" (DWC-73) (Attachment B) from the physician after each office visit. Furnish a copy of this work status report to your immediate supervisor.</li> <li>4. Administrative Leave for medical 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.</li> <li>5. Complete a Notice of Leave form documenting duration of medical appointment and provide to immediate supervisor for approval.</li> <li>6. Employees engaged in outside employment who are receiving TIBs, must report their outside employment income to the TPA. Failure to report outside employment income is a violation of this policy and under certain circumstances may be a violation of the Workers' Compensation Act.</li> <li>7. Transportation for employee on-the-job follow-up appointments shall be the responsibility of the employee.</li> <li>8. Any use of alcohol that conflicts with instructions provided by a physician; the illegal use of prescription drugs or controlled substances; or the use of any over-the-counter medication at a dosage level different than recommended by the manufacturer or being used for a purpose other than intended by the manufacturer. Drugs prescribed by a physician in the course of treatment are excluded from this prohibition.</li> </ol>
<b>Department</b>	<ol style="list-style-type: none"> <li>1. Ensure compliance with the procedures contained herein. The Human Resources Specialist (HRS) for each Department is responsible for forwarding the following forms to the TPA (Attachments A – D): <ol style="list-style-type: none"> <li>a. "City of San Antonio Supervisor's Report of Injury or Illness", (Attachment A)</li> </ol> </li> </ol>

**Department  
(Cont.)**

- b. "Work Status Report" (DWC-73), (Attachment B)
  - c. "City of San Antonio Vehicle Accident Report", (Attachment C) if applicable,
  - d. "Supplemental Report of Injury" (DWC-6), (Attachment D). The HRS is responsible for completing.
2. The Departmental Time and Attendance Specialist is responsible for forwarding the following forms to the TPA (Attachment E):
    - a. "Employer's Wage Statement" (DWC-3)
  3. Communicate this administrative directive when applicable to ensure compliance with the Workers' Compensation Program.
  4. Paid Administrative Leave shall be 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 treating physician's appointments or appointments for rehabilitative therapy. Administrative Leave for this purpose applies to employees who have not reached (MMI), who provide documentation of the appointment from the medical provider prior to the time of the appointment and documentation of the time the appointment ended. 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. Qualified employees are strongly encouraged to schedule appointments during times best suited to meet the needs of their department.
  5. Paid Administrative Leave shall also be granted to employees requiring medical attention on the day an accident occurs; in such cases, the Paid Administrative Leave may not be for a period greater than one (1) working day.
  6. The proper Administrative Leave Payroll Code is **WC01**. To ensure accurate time tracking, this Payroll Code must not be used for any other purpose
  7. Monitor the progress of the employee through periodic contacts and encourage the employee to keep all physician appointments and medical treatment appointments.
  8. Transportation to and from the physician's office and/or medical facility may be provided by COSA at the time of the accident and on the same date as the accident.

<p><b>Supervisors</b></p>	<ol style="list-style-type: none"> <li>1. Complete a “City of San Antonio Supervisor’s Report of Injury or Illness”, and provide the document to the HRS (Attachment A) within the next business day from first knowledge of the injury or illness.</li> <li>2. If an injury is a result of a motor vehicle accident, complete a “City of San Antonio Vehicle Accident Report” for damages to a COSA vehicle or privately owned vehicle and forward report to Risk Management, Safety Section within 72 hours. (Attachment C).</li> <li>3. Notify the HRS, on a timely basis of any changes in the injured employee’s work status, such as returning to work or going back on “off work” status, being placed on modified duty, or when modified duty restrictions are lifted.</li> </ol>
<p><b>Risk Management</b></p>	<ol style="list-style-type: none"> <li>1. Ensure compliance with the Texas Workers’ Compensation Law.</li> <li>2. Coordinate all COSA Workers’ Compensation claims with COSA departments, the TPA, and the DWC.</li> <li>3. Act as liaison between the TPA and COSA departments.</li> <li>4. Assist the TPA, COSA departments, and injured employees as necessary.</li> <li>5. Conduct training sessions and updates on changes in the Workers’ Compensation law, policies and procedures.</li> <li>6. Provide claim status reports to Department Directors quarterly, or upon request.</li> </ol>

**Appeal Process**

Under the provision of the Texas 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 Office of Injured Employee Counsel.

Time associated with this appeals process is not COSA 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 TDI Division of Workers’ Compensation (DWC) at 1-888-327-8818

**Discipline**

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

**Attachments**

<b>Attachment A</b>	City of San Antonio Supervisor's Report of Injury or Illness
<b>Attachment B</b>	Work Status Report (DWC-73)
<b>Attachment C</b>	City of San Antonio Vehicle Accident Report
<b>Attachment D</b>	Supplemental Report of Injury (DWC-6)
<b>Attachment E</b>	Employer's Wage Statement (DWC-3)

This directive supersedes all previous correspondence on this subject. Information and/or clarification may be obtained by contacting the Finance, Risk Management Division.



**EMPLOYEE ACKNOWLEDGMENT FORM  
FOR**

**ADMINISTRATIVE DIRECTIVE 4.84  
Workers' Compensation Program**

**Employee:**

I acknowledge that on \_\_\_\_\_, 20\_\_\_\_, I received a copy of Administrative Directive 4.84 Workers' Compensation Program. I understand if I'm placed off work for a workers' compensation injury, my lost time days will be designated as FLMA in accordance with the Family Medical Leave Act. I should contact my Human Resources Representative if I have any questions.

\_\_\_\_\_  
Employee Name (Print)

\_\_\_\_\_  
Department

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee SAP ID Number

# ATTACHMENT A

	<h2 style="margin: 0;">CITY OF SAN ANTONIO</h2> <h3 style="margin: 0;">Supervisor Report of Injury or Illness</h3>		
<b>MUST be completed and submitted within 24 hours of the incident</b> <input type="checkbox"/> Initial <input type="checkbox"/> Amended Report #: _____ (Photos: <input type="checkbox"/> No <input type="checkbox"/> Yes By: _____)		<b>DEPART CODE# (Required)</b> _____	<b>FOR RISK MGMT USE ONLY</b> 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-____	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: _____		16. Phone Number: (____) _____	28. Worksite Location of Injury (stairs, dock, etc.): _____
17. Mailing Address Street or P. O. Box City State Zip Code _____ City _____ State _____ Zip Code _____			29. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Street or P. O. Box _____ County _____ City _____ State _____ Zip Code _____
18. Doctor's Name: _____		19. Phone Number: (____) _____	30. Cause of Injury (fall, tool, machine, etc.): _____
20. Doctor's Mailing Address (Street or P. O. Box) _____ City _____ State _____ Zip Code _____			31. List Witnesses: _____
32. Return to work date/or expected (m/d/yy): _____		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](mailto:RiskMgmt@sanantonio.gov)

# ATTACHMENT B

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

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

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

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

(a) will allow the employee to return to work as of \_\_\_\_\_ (date) without restrictions.

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

(c) has prevented and still prevents the employee from returning to work as of \_\_\_\_\_ (date) and is expected to continue through \_\_\_\_\_ (date).

The following describes how this injury prevents the employee from returning to work:

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

<b>14. POSTURE RESTRICTIONS (if any):</b>		<b>17. MOTION RESTRICTIONS (if any):</b>		<b>19. MISC. RESTRICTIONS (if any):</b>	
Max Hours per day: 0 2 4 6 8	Other	Max Hours per day: 0 2 4 6 8	Other	<input type="checkbox"/> Max hours per day of work: _____	
Standing <input type="checkbox"/>		Walking <input type="checkbox"/>		<input type="checkbox"/> Sit/Stretch breaks of _____ per _____	
Sitting <input type="checkbox"/>		Climbing stairs/ladders <input type="checkbox"/>		<input type="checkbox"/> Must wear splint/cast at work	
Kneeling/Squatting <input type="checkbox"/>		Grasping/Squeezing <input type="checkbox"/>		<input type="checkbox"/> Must use crutches at all times	
Bending/Stooping <input type="checkbox"/>		Wrist flexion/extension <input type="checkbox"/>		<input type="checkbox"/> No driving/operating heavy equipment	
Pushing/Pulling <input type="checkbox"/>		Reaching <input type="checkbox"/>		<input type="checkbox"/> Can only drive automatic transmission	
Twisting <input type="checkbox"/>		Overhead Reaching <input type="checkbox"/>		<input type="checkbox"/> No work / _____ hours/day work: <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding	
Other: <input type="checkbox"/>		Keyboarding <input type="checkbox"/>		<input type="checkbox"/> Must keep _____ <input type="checkbox"/> elevated <input type="checkbox"/> clean & dry	
15. RESTRICTIONS SPECIFIC TO (if applicable): <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 checked="" type="checkbox"/> Back <input type="checkbox"/> Right Arm <input type="checkbox"/> Left Foot/Ankle <input type="checkbox"/> Neck <input type="checkbox"/> Right Foot/Ankle		18. LIFT/CARRY RESTRICTIONS (if any): <input type="checkbox"/> May not lift/carry objects more than _____ lbs. for more than _____ hours per day <input type="checkbox"/> May not perform any lifting/carrying		20. MEDICATION RESTRICTIONS (if any): <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)	
		Other: _____		Other: _____	
16. OTHER RESTRICTIONS (if any):					

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

### PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

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





## CITY OF SAN ANTONIO Supervisor Report of Vehicle Accident

Print Form

**MUST be completed and submitted within 24 hours of the accident.**  
 Initial  Amended Report #: \_\_\_\_\_ (Photos:  No  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		19. 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 $\pm$ 32° <input type="checkbox"/> Cold $>$ 32° $<$ 60°		
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:
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:**

**NAMES AND ADDRESSES OF OCCUPANT AND WITNESSES: ) (Use additional paper if needed and attach to this report)  Not applicable**

68. NAME OF 1 <sup>ST</sup> OCCUPANT OF CITY VEHICLE:	69. STREET ADDRESS:	70. CITY:	71. STATE:	72. ZIP CODE:	73. PHONE NUMBER:
74. NAME OF 2 <sup>ND</sup> OCCUPANT OF CITY VEHICLE:	75. STREET ADDRESS:	76. CITY:	77. STATE:	78. ZIP CODE:	79. PHONE NUMBER:
80. NAME OF 1 <sup>ST</sup> OCCUPANT OF OTHER VEHICLE:	81. STREET ADDRESS:	82. CITY:	83. STATE:	84. ZIP CODE:	85. PHONE NUMBER:
86. NAME OF 2 <sup>ND</sup> OCCUPANT OF OTHER VEHICLE:	87. STREET ADDRESS:	88. CITY:	89. STATE:	90. ZIP CODE:	91. PHONE NUMBER:
92. NAME OF 1 <sup>ST</sup> WITNESS (IMPORTANT):	93. STREET ADDRESS:	94. CITY:	95. STATE:	96. ZIP CODE:	97. PHONE NUMBER:
98. NAME OF 2 <sup>ND</sup> WITNESS (IMPORTANT):	99. STREET ADDRESS:	100. CITY:	101. STATE:	102. ZIP CODE:	103. PHONE NUMBER:



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 <sup>th</sup> 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 \_\_\_\_\_



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)**

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

**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.

