Guadalupe County
Human Resources Department

Lois Elley, Assistant Human Resource Director
211 W. Court Street, Seguin, Texas 78155 Phone: (830) 303-8862
Fax: (830) 401-4960

PROCEDURES FOR FILING & REPORTING WORKERS COMPENSATION INJURIES

Guadalupe County is committed to providing a safe workplace for our employees. Preventing work related illness and injury is our primary goal. We want to maintain a safe environment and see that you receive the appropriate medical treatment for your injury.

If an accident occurs these procedures must be followed:

1. It is the injured employee's responsibility to report his/her accident or incident to their supervisor or department head **immediately.**

2. The supervisor or department head **must** report the injury or incident to Lois Elley (Human Resource Manager/Risk Manager) fax number 830-401-4960 or phone number 830-303-8862 in the Human Resources Department **within 24 hours.**

3. The injured employee **must** submit to a drug and/or alcohol test within 24 hours of any accident/incident or post-accident. All alcohol and drug testing will be done at:

   - **Guadalupe Regional Emergency Room, <u>if injured.</u>** GRMC main line is (830) 379-2411.

   - **Dr. Frank Wright, <u>if injured</u>**. He is located at 411 S. King St. Seguin. Hours are Mondays thru Fridays from 7 a.m. to 7 p.m., the main line is (830) 484-4200. (Employer must take GRMG Treatment Authorization Form).

   - **Guadalupe Regional Urgent Care in New Braunfels, <u>if injured</u>**. They are located at 1751 S. State Hwy 46, Ste 104, New Braunfels, TX 78130. Hours are Sunday through Saturday from 7 a.m. to 7 p.m., the main line is (830)433-7816. (Employee MUST take with them the GRMG Treatment Authorization Form).

   - **Guadalupe Regional Outpatient Lab <u>for drug screen purposes only</u>**. Their hours of operation are between 7:00 a.m. to 4:00 p.m. Monday through Friday. GROL main line is (830) 401-7260.

4. The supervisor or department head **must** complete the First Report of Injury, **<u>NOT</u>** the injured worker and forward this form to Human Resources Department immediately.

5. The injured employee **must** complete the **Employee Injury Statement** and all forms that require an employee signature and forward, along with the First Report of Injury, to the Human Resources Department. Ex. (Medical Release Form, etc.).

6. Any witness to the accident **must** complete the **Witness Statement** form and forward this form to the Human Resources Department along with the First Report of Injury. If there is no witness, please indicate this on the witness statement form.

7. If the employee is going to **miss any work** because of his/her work related injury they must notify their department head or supervisor and his/her adjustor Amber Thornton, phone # (210) 728-3290. Lost time is only eligible if the treating physician or emergency room doctor takes the employee off work.

8. If the injured employee misses any time from work to attend an office visit, physical therapy, etc. the employee **must** submit a **Leave Request Form** to their supervisor or department head that indicates the time off as workers compensation. The employee may be entitled to post injury wages.

9. The injured employee must tell his or her employer within 30 days of the date of the injury, or within 30 days of the date the worker first knew the illness might be work-related. **If an injured worker does not report his/her injury to their employer within 30 days, they could lose their right to receive benefits.**

Our goal is to see that the injured employee receives the necessary medical treatment for their injury, so that they may return to work as soon as possible.

Guadalupe County will make every reasonable effort to provide suitable return to work opportunities for every employee who is unable to perform his/her regular employee's physical abilities.

If the injured employee is not physically capable of returning to full duty, our return to work program provides opportunities to perform his or her regular job with modifications or, when available, to perform alternate temporary work that meets the injured employee's physical capabilities.

Human Resources and the Deep East Texas Self Insurance Fund are available to assist you with any questions that you may have regarding Workers Compensation Benefits.

Athens Administrators Workers Compensation:
Amber Thornton
Phone Number (210) 728-3290
athornton@athensadmin.com

Please feel free to contact Lois Elley at (830) 303-4188 ext. 1282.

By signing this form, I certify that the above policies and procedures have been explained to me and I understand the instructions provided.

Employee Signature: ______________________________

Employee Name (printed): ______________________________ Date: ____________________

Athens Administrators
Workers' Compensation

Deep East Texas Self Insurance Fund
Serving Texas Since 1974

Effective 1/1/2025

Employer Information

Employer Information	Workers' Compensation Employer Contact
Name: Guadalupe County Address:211 W. Court St. City: Seguin State, Zip: Texas, 78155 Phone: (830) 303-8862	Name: Lois Elley Phone: (830) 303-4188 Ext. 1282 Fax: (830) 401-4960 Email: Lois.Elley@co.guadalupetx.gov

Athens Claims Contacts

Senior Claims Examiner	Claims Supervisor	Assistant Claims Examiner
Amber Thornton Phone: 210-728-3290 athornton@athensadmin.com	Judith Dye Phone: 925-826-1268 jdye@athensadmin.com	Makenzie Reeves Phone: 210-728-3277 mreeves@athensadmin.com

Claim Information

By Phone: 833-226-3398
Available 24/7 for Emergency Reporting

Additional forms are available online at https://detsif.com/forms/

Online: Athens' Client Portal
https://portal.athensadmin.com

If you need access to the portal, please contact operations@athensadmin.com

Please email any forms to: mreeves@athensadmin.com; jdye@athensadmin.com; rgarcia@detsif.com; claims@detsif.com

Pharmacy Benefits	Preauthorization Information	Bill Review
Rx Bridge First Fill: Text DETSIF to 833-FRSTFILL Pharmacy Help Desk: 833-RxBridge	Injury Management Organization (IMO) Phone: 888-645-1200 Fax: 888-275-9946 preauth@injurymanagement.com	Injury Management Organization (IMO) Provider Line: 888-245-5738 Fax: 888-243-1990 https://injurymanagement.com/bill-status/

Program Contacts

DETSIF Contact	Athens Administrators
Dustin Hill, Executive Director Mailing: PO Box 130, Lufkin, TX 75901 Physical: 5036 Champion Dr, Lufkin, TX 75901 Office: 409-384-5444 Cell: 936-465-2556 Email: dhill@detsif.com Website: www.detsif.com	Billing and Mailing Address: PO Box 696 Concord, CA 94522-0696 Phone: 866-482-3535 Fax: 925-889-2410 Website: www.athensadmin.com

ATHENS ADMINISTRATORS

GUADALUPE COUNTY
FIRST REPORT OF INJURY

EMPLOYEE INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Employee Name: ______________________________________ SS#: ______________
Last First M.I.
Date of Birth: ________ Home Phone #: (____) ______-________ Race: ____________ Sex: M F

Mailing Address: ____
Street City State/Zip County
Marital Status (Circle One): Married Widowed Separated Single Divorced

Number of Dependent Children: _____ Spouses Name: ____________________

Length of Service: In Current Position: _____Months _____ Years In Occupation: _____Months _____Years

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INJURY INFORMATION: (ALL INFORMATION MUST BE COMPLETED)

Date of Injury: ______________ Time of Injury: ________ AM PM (Circle One)
Was there any lost time: Yes No (Circle One) Date Lost Time Began (if applicable):__________

Nature of Injury (Circle One): Abrasion Amputation Allergic Reaction Bite Break Burn Concussion
Contusion Crushed Contag. Disease Dislocation Dust Eye Injury Fracture Foreign Body Hernia
Heat Exh. Inflammation Infection Laceration Poison Puncture Sprain Strain Other _______

Body Part Injured: Left Right **(Circle One)**
Ankle Arm Back Ear Elbow Eye Finger(s) Face Finger(s) Foot Groin Hand Head
Knee Leg Mouth Neck Toe Wrist Multiple No Injuries Other _________

How and Why Injury/Illness Occurred: ____
____
Did you get any type of medical treatment for your injury? Yes No (Circle One)
If yes, please give the following Doctor/Facility information where treatment was rendered:
Doctor/Facilities Name: ____
Doctor/Facilities Mailing Address: ____
Street City State/Zip
What is expected return to work date? ______________
Were you doing your regular job? Yes No (Circle One)
Worksite Location of Injury (stairs, side of road, office, etc): ______________________________

Cause of Injury (Circle One): Assault Bite Burn Caught Btwn Cut/Scrape Exposure
Fall/Slip Foreign Body Motor Vehicle Needle Stick Sprain Step Strain Strike Against
Other _______

Address where injury occurred: ____
Street City State/Zip County
Witness (es) to incident: ____

Supervisor's Name: ______________________ Phone Number: (____) ______-__________.

Supervisor's Signature: ______________________ Date Reported: ____________________

*****************FOR HUMAN RESOURCE USE ONLY*****************

DOH: __________ Occupation: ________________________ Dept: ________________ Pay Rate: $_______
Last Paycheck: $________ for _______hrs. NAICS (6 digit) ________ NCCI Code: ________

GUADALUPE COUNTY FIRST REPORT OF INJURY

ACCIDENT INVESTIGATION REPORT

Accident Date: ________ Accident Time: _____am/pm Investigation Date: ________

Location at time of accident: ____

____

Did injury result: Yes No If yes, provide employee(s) name(s): _______________

Social Security #: ____________________ Date of Birth: _____________

Describe type of injury: ____

Did property damage result: Yes No

If yes, describe property damage and owner: _________________________________

____

Name of Witness (es): ____

Description of Accident: ____

____

____

Corrective action taken, by whom, and date complete: _________________________

____

____

Was a permit issued? Yes No

If yes, attach a copy of the police report.

____
Supervisor Signature/Date

Revised 9/20/2023 HR

GUADALUPE COUNTY FIRST REPORT OF INJURY

INJURED EMPLOYEE'S STATEMENT

Name: ______________________________ **SSn:** ______________________

Address: ______________________________ Phone: ( ) -

____

Date of Birth: ____/____/______ Supervisor: ________________

Injury Date: ____/____/______ Injury Time: __________ am/pm

Nature of Injury: __________________________________

Location at time of accident: ____

Describe how the accident/injury occurred:

____

____

____

____

____

____

____

____

____

Do you refuse medical treatment for this injury? Yes No

______________________________ ______________________________

Supervisor Signature/Date Employee Signature/Date

GUADALUPE COUNTY FIRST REPORT OF INJURY

WITNESS STATEMENT

Name: ______________________________ SSN: ______________________

Address: ______________________________ Phone: (___) _____-__________

____

Date of Birth: ____/____/_____ Supervisor: ____________________

Location at time of accident: ____

To the best of your knowledge, explain how the injury/accident occurred:

____

____

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____

____

____

____

____________________________ ____________________________

Supervisor Signature/Date Witness Signature/Date

Revised 9/20/2023 HR

GUADALUPE COUNTY FIRST REPORT OF INJURY

Medical Release

____
Employee Name (Print)

I authorize and request my physician or other person or any hospital or other institution by who, or in which I have received medical treatment for a work-related injury and/or illness, to furnish a representative of Guadalupe County full information relative to such treatment of, or residence in any hospital or institution and to supply said representative with history, reports, consultations, diagnostic films and/or x-rays, or any other medical documentation pertaining to my work-related injury.

A photostatic copy and/or facsimile of this release shall be considered as effective and valid as the original.

____
Employee Signature

____
Printed Name

______/_____/_________
Date

Guadalupe Regional
MEDICAL CENTER

1215 E. Court Street
Seguin, TX 78155
830.401.7237
FAX 830.401.7588
www.grmedcenter.com

AUTHORIZATION TO RELEASE/ACCESS PROTECTED HEALTH INFORMATION

Patient Name ____

Date of Birth ____________________ SSN ________________ Phone ________________

Address ____________________________ City________________ ST ________ Zip ________

I authorize Guadalupe Regional Medical Center, or business associate working on their behalf, to release information contained in the medical record on the patient identified above. Information released/requested will cover the following dates of service: From ______________ Through ______________

Information Released:

- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Entire record (excludes Psychotherapy notes)
- ☐ Laboratory Reports
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Other ______________________________
- ☐ Radiology Studies (CD only)
- ☐ Therapy Records

Purpose of Request: ☐ Continued Treatment ☐ Third Party Payment/Insurance* ☐ Legal Review* ☐ Other (Specify)* ______________ ☐ Personal Review*

Medical Records will be delivered as follows: (Check only one box)

- ☐ I will pick up copies of my records
- ☐ Records will be picked up by ______________________________ (photo ID required)
- ☐ Provide my records to the **physician/facility** listed below:

Name/Organization	
Address	
Phone	

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless revoked earlier, the expiration date of this Authorization will be 90 days from the date of signature.
- That information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by privacy regulations.
- The information authorized for release may include protected health information related to mental health or substance use/abuse. Release of mental health records or psychotherapy notes my require consent of the treating provider or court order.
- If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or HIV related information; you must specifically authorize the release of such information to the above named recipient by initialing: Yes ________ (initial) or No ________ (initial)
- That Guadalupe Regional Medical Center will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization.
- I may request a copy of this signed authorization for my records.

______________________________ ______________________ ______________

Signature of Patient or Patient's Legal Representative** Relationship to patient Date Signed

*Fees apply **May be required to show proof of representative status

GRMG Treatment Authorization – Employee Services

Company Name: ____Guadalupe County______________________________________

Address: ____211 W. Court St. Seguin, TX 78155________________________________

Phone: __(830) 303-8862__ After hours phone: _(830) 660-8611_ Fax: (830) 401-4960__

Person authorizing treatment (print name): _____Lois Elley________________________

Email address of person authorizing treatment: ___Lois.Elley@guadalupetx.gov_______

Employee Name: ______________________________________

Date of Injury: ___________________________________

Social Security Number: ________________ DOB: __________

Date Authorization Expires: __________________ Time: _____________

Service Requested: __Treatment for work related injury_______

Medical Evaluation:

✓ Work Related Injury
(Job description required)

Drug/Alcohol Testing:

- ❑ Post-Accident
- ❑ Random
- ❑ Pre-Employment
- ❑ For Cause
- ❑ Follow up (DOT)
- ❑ Return to DOT (DOT only)

❑ Other: _BAT (Breath & Alcohol Test)_

DWC Form-73 to be given to:

- ☐ Employee
- ☐ Fax to Employer:

  Guadalupe County
  Lois Elley
  Assistant HR Director
  Fax (830) 401-4960
  Phone (830) 303-4188 Ext 1282

Bills sent to:

- ☐ Fax to:

  ATHENS ADMINISTRATORS
  PO Box 696
  Concord, CA 94522-0696
  Phone: (866) 428-3535
  Fax: (925) 889-2410

Clinic location:

Frank Wright, M.D.
411 S. King, Ste A
Seguin, TX 78155
P (830) 484-4200
F (830) 386-0891

Guadalupe Regional Urgent Care in Clear Springs
1751 S. State Hwy 46, Ste 104
New Braunfels, TX 78130
P (830) 433-7816

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 su obligación reportar 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

MUST BRING BACK FROM DR.

PART I: GENERAL INFORMATION

5. Doctor's Name and Degree	(For Division use 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	7. Clinic/Facility Phone	10. Employer's Fax # or Email Address (if known)
4. Employee's Description of Injury/Accident	8. Clinic/Facility Address (street address)	11. Insurance Carrier
	City State Zip	12. Carrier's Fax # or Email Address (if known)

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c), IF 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)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Standing	☐	☐	☐	☐	☐	____
Sitting	☐	☐	☐	☐	☐	____
Kneeling/Squatting	☐	☐	☐	☐	☐	____
Bending/Stooping	☐	☐	☐	☐	☐	____
Pushing/Pulling	☐	☐	☐	☐	☐	____
Twisting	☐	☐	☐	☐	☐	____
Other:	☐	☐	☐	☐	☐	____

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist
☐ L Arm ☐ R Arm ☐ Neck
☐ L Leg ☐ R Leg ☐ Back
☐ L Foot/Ankle ☐ R Foot/Ankle
☐ Other: ________

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	____
Climbing stairs/ladders	☐	☐	☐	☐	☐	____
Grasping/Squeezing	☐	☐	☐	☐	☐	____
Wrist flexion/extension	☐	☐	☐	☐	☐	____
Reaching	☐	☐	☐	☐	☐	____
Overhead Reaching	☐	☐	☐	☐	☐	____
Keyboarding	☐	☐	☐	☐	☐	____
Other:	☐	☐	☐	☐	☐	____

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than ___ lbs. for more than ___ hours per day
☐ May not perform any lifting/carrying
☐ Other: ________

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: ______
☐ Sit/Stretch breaks of ______ per ______
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / ☐ ___ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep ________:
☐ Elevated ☐ Clean & Dry
☐ No skin contact with: ________
☐ Dressing changes necessary at work
☐ No Running

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ 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:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on ________ (date) at ___:___ am/pm
☐ Referral to/Consult with ________ on ________ (date) at ___:___ am/pm
☐ Physical medicine ___ X per week for ___ weeks starting on ________ (date) at ___:___ am/pm
☐ Special studies (list): ________ on ________ (date) at ___:___ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date/Time of Visit	Employee's Signature	Doctor's Signature	Visit Type:	Role of Doctor:
Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ DWC-selected RME ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor ☐ Other doctor