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 Name: Guadalupe County Address:211 W. Court St. City: Seguin State, Zip: Texas, 78155 Phone: (830) 303-8862	**Workers' Compensation Employer Contact** 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 Amber Thornton Phone: 210-728-3290 athornton@athensadmin.com	**Claims Supervisor** Judith Dye Phone: 925-826-1268 jdye@athensadmin.com	**Assistant Claims Examiner** 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 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	**Athens Administrators** 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

Revised 9/20/2023 HR

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Supervisor Signature/Date Witness Signature/Date

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

GUADALUPE REGIONAL MEDICAL GROUP

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 deber 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 consulte la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

MUST BRING BACK FROM DR. OFFICE

PART I: GENERAL INFORMATION

1. Injured Employee's Name
2. Date of Injury
3. Social Security Number
4. Employee's Description of Injury/Accident
5. Doctor's/Delegate's Name and Degree
6. Clinic/Facility Name
7. Clinic/Facility/Doctor Phone & Fax
8. Clinic/Facility/Doctor Address (street address)
City State Zip
9. Employer's Name
10. Employer's Fax # or Email Address (if known)
11. Insurance Carrier
12. Carrier's Fax # or Email Address (if known)
Date Being Sent

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

- 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):

* 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.

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)

EXAM D

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