
# AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:_____

**TO WHOM IT MAY CONCERN:**

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or any associate, assistant, representative, agent, or employee thereof, any and all desired information (including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and/or drug tests, X-rays, X- ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or future information, but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name)_____

SIGNED:_____ DATED:_____

*Copies of this signed authorization will be considered just as valid as the original. This is not a release of claims for damages.*

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

State Office of Risk Management
PO Box 13777
Austin, TX 78711-3777
(512) 475-1440
Fax: (512) 370-9025

# Instructions
# Authorization for Release of Information

## Required:

This document is required immediately after sustaining a work-related injury. The injured employee should complete this release form. This enables SORM to obtain copies of relevant medical documents from healthcare provider that will assist in the handling of the claim.

## Filing Deadline:

The form must be received by SORM no later than the 5th calendar day after the First Report of Injury or Illness (DWC-1S) to the claimant's employer.

## Completed by:

The employee must complete this form. If the employee is incapacitated, the spouse, child, or legal guardian may sign the form. **THIS FORM MUST BE SIGNED AND DATED.** The Claims Coordinator should make this form available for all injuries.

## Instructions:

1. The injured employee must clearly print his or her name on the patient line.
2. The injured employee must clearly print his or her name on the second line.
3. The injured employee must sign and date the form.

## Distribution:

The Claims Coordinator shall retain the original for the agency file and fax or mail a copy to:

State Office *of* Risk Management
PO Box 13777
Austin, TX 78711
Fax: (512) 370-9025

**Notice:** With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.

SORM
State Office of Risk Management

# EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name:_____
Last First M.I. Maiden

Address: _____

City: _____ State:_____ ZIP:_____

Primary Phone Number:_____

Secondary Phone Number: _____

Email address: _____

Social Security:_____ Gender: ☐M ☐ F

Date of Injury: _____

Employer:_____

Job Title:_____

Work Schedule: _____

1) What was the exact location of the accident? Include street address if possible:

2) What was happening at the time? What was going on around you, what were you doing, what were other people doing?:

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date_____ Time_____

Name: _____ Title_____ Phone Number: _____

6) List all known witnesses (continue on back if necessary): 1. Name _____ Phone:_____

2. Name _____ Phone: _____ 3. Name:_____ Phone:_____

7) Who is your Primary Care Physician or family doctor? Name:_____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name:_____ Phone: _____

Name:_____ Phone: _____

Name:_____ Phone: _____

9) Has a doctor taken you off work? ☐ Yes ☐ No If Yes, when was the first day you missed work?_____

10) If the doctor took you off of work, have you returned to work? ☐ Yes ☐ No If No, when do you think you will return to work?_____

11) Date of Last Appointment: _____ Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ☐ Yes ☐ No If Yes, please enter injury dates and body parts injured:

*By affixing my signature, I attest that all information on this form is accurate and true:*

Signature:_____ Date:_____

# Instructions
# Employee's Report of Injury

## Purpose of Form:

The injured employee completes this form to provide the State Office of Risk Management (SORM) with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury in order to help expedite benefits.

## Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the *First Report of Injury or Illness Form* (DWC-1S) is reported by the agency.

## Completed by:

This form shall be completed by the injured employee with assistance from the Claims Coordinator, if needed.

## Instructions:

1. The employee will address each of the questions completely and use additional pages if necessary. The adjuster needs a complete picture of the events surrounding the injury and how the injury occurred. Witnesses' names and phone numbers, physicians/treatment provider's names and phone numbers and work status is needed. The employee should enter any previous workers compensation claims information including body parts injured.

2. The injured employee will sign and date the form thereby attesting that all information on the form is true and complete.

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P.O. Box 13777
Austin, TX 78711
Fax: (512) 370-9025

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SORM
State Office of Risk Management

# WITNESS STATEMENT

***MUST BE TYPED OR PRINTED***

Injured Employee Name: _____ Date of Injury: _____

SORM Claim Number: _____ Statement Taken By: _____

Witness Name: _____

Witness Email Address: _____

Residence Address: _____

Primary Telephone: _____ Secondary Telephone: _____

Witness Employer: _____

On _____ (date), at about _____ (time) in the ☐ a.m. / ☐ p.m., I was in or at _____ when an accident involving the above employee is reported to have occurred.

**SELECT CHOICE A, B, OR C BELOW:**

Check only *one* box:

A. ☐ I saw the incident. The accident occurred in the following manner:

Other pertinent information and source:

B. ☐ I did not see the incident. Information given to me by (name of person):

Indicate how it occurred:

Other pertinent information and source:

C. ☐ I know nothing whatsoever about the incident.

_____ _____

Signature Date

# Instructions Witness Statement

## Required:

Immediately after receiving notice of any injury, the Claims Coordinator should determine the names, addresses, and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to SORM.

## Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the first notice of injury is reported to the agency.

## Completed by:

This form should be completed by the person giving the statement with assistance from the Claims Coordinator.

## Instructions:

1. Be as specific and complete as possible.
2. Except for the witness signature, the statement should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
3. Please provide the SORM claim number, if known.
4. The witness may have actually seen the incident or may have acquired knowledge about the accident from another source. The witness information may relate to how the incident occurred or to something else that is relevant. Sometimes you will be given a witness name but, when asked, the witness may deny any knowledge of the incident. In such a case the third box should be checked.
5. If the space provided on the form is insufficient please attach additional information.

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# EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE

Employee's Name: _____ Date of Injury:_____

Employee's SSN: _____ Agency:_____

**You are not required to use your leave.** Texas Labor Code §501.044 allows an injured state employee to elect to use accrued sick and annual leave before receiving income benefits. NOTE: Sick leave must be exhausted before annual leave may be used. Other categories of leave (compensatory leave, holiday leave, administrative leave, etc.) may not be used prior to sick and annual leave.

**Select only ONE election, either Election 1 or Election 2 below:**

☐ **ELECTION 1—Choose A, B, or C**

When I lose time from work due to this injury or illness, I elect to use all of my accrued sick leave **AND**:

☐ A. All of my accrued annual leave.

☐ B. A portion of my accrued annual leave (enter number below).

☐ C. None of my accrued annual leave.

If you selected B, how much of the portion of your leave do you wish to donate? _____

☐ **ELECTION 2**

When I lose time from work due to this injury or illness, I elect to not use any accrued sick leave or annual leave. I understand I am not entitled to workers' compensation income benefits until after the seven (7) calendar day waiting period.

If you know, please indicate how hours you have available: _____ Sick hours; _____ Annual hours

## MONTHLY TEMPORARY INCOME BENEFITS (TIB) ELECTION

☐ I elect to change my Temporary Income Benefits frequency from weekly to monthly. For more information about TIB, please visit the Texas Dept. of Insurance Website (https://www.tdi.state.tx.us/pubs/factsheets/tibs.pdf).

By signing below, I signify that I understand that I may not change my election after my eighth (8th) day of disability and that I have read the instructions on page 2.

_____ _____ _____ _____

Employee's Signature Date Coordinator's Signature Date

# INSTRUCTIONS

## Employee's Election Regarding Utilization of Sick and Annual Leave

Injured employees may elect to use accrued sick leave and all, part, or none of their accrued annual leave for time missed from work due to the work related injury. Accrued sick leave and accrued annual leave are the amounts of paid leave available at the time of injury in addition to leave earned after the injury. The following details the effects of the different choices available to you.

## If You Choose Election 1

- You must use all accrued sick leave but may elect to use all, some, or none of your accrued annual leave.
- All sick leave must be exhausted before annual leave may be used.
- If you select 1A and return to work but later have additional days of disability, you must use any accrued sick and annual leave before receiving workers' compensation income benefits.
- If you select 1B, you must use any sick leave balance and any authorized annual leave before you will be eligible to receive workers' compensation income benefits.
- If you select 1C, you must use any/all accrued sick leave before receiving workers' compensation income benefits.
- Workers' compensation income benefits do not begin until the eighth day of disability. Employees who are disabled for at least 14 days will receive retroactive benefits for any portion of the seven-day waiting period not paid by leave.
- You will continue to receive your full pay as long as you have accrued time to use and have authorized your agency to use it for your injury. If your elected leave is exhausted, you may receive income benefits to replace a portion of your lost wages. This may be 70% or 75% of your average weekly wage depending on your wages at the time of your injury.
- It is recommended that you consult with your Human Resources Department to discuss the impact of your selection on your leave balances and insurance benefits should you be off work for an extended period of time.

## If You Choose Election 2

- You choose to not use any sick or annual lave for your compensable injury. Your agency may immediately place you in a leave without pay status.
- You may not receive any workers' compensation income benefits for the first seven (7) calendar days you are unable to work. If eligible, your income replacement benefits will begin on the 8th day of disability and employees who are unable to work for 14 days will receive retroactive benefits for the first seven days. You will be paid at a rate of 70 or 75% of your weekly wage depending on your wages at the time of your injury.

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