Submit within 5 days of TWCC 1S submission

EMPLOYEE'S REPORT OF INJURY
(SORM-29)

Dear Claimant:

We have 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 MI MAIDEN	Social Security:_____ Date of Injury: _____
Address:_____ City: _____ State: _____	Employer:_____ Job Title: _____Wk Schedule:_____

1) What was the exact location of the accident (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 body parts were injured?

5) To whom and at what time did you report you were injured? Date_____ Time_____

Name_____ Title_____

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

Name _____ Phone: _____ Name:_____ Phone:_____

7) Which doctor did you see first? Date_____ Name:_____

Address:_____ Phone: _____

8) Has a doctor taken you off work? □ Yes □ No	If yes, what was the first day you missed work ?_____
9) If the doctor took you off work, have you returned to work? □ Yes □ No	If no, when do you think you will return to work?_____
10) Date of Last Appointment: _____	11) Have you lost any wages due to your injury? □ Yes □ No

12) Please list names and phone numbers of other doctors or treatment providers have you seen regarding your injury:

Name:_____ Phone: _____

Name:_____ Phone:_____

Name:_____ Phone: _____

13.Have you had previous workers compensation injuries? □ Yes □ No If Yes, please enter dates of injuries and the body parts injured.

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

Signature:_____	Date signed:_____

Notice: With few exceptions, an individual is entitled on request to be informed about the information that 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 the information about the individual that is incorrect.

EMPLOYEE'S REPORT OF INJURY
(SORM-29)

Purpose of Form:	**The injured employee completes this form to provide SORM with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury. This will help to expedite benefits in a more timely manner.**
Filing Deadline:	**The form must be received by SORM no later than the 5th calendar day after the First Report of Injury or Illness (TWCC-1S) is reported to the agency.**
Completed by:	**The claimant with assistance from the claims coordinator, if needed.**
Instructions:	**1. The claimant will address each of the questions completely and is to 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, physician/Treatment Providers names and phone numbers and work status is needed. The claimant should enter any previous workers compensation claims and the body parts injured**
	2. The Claimant will sign and date the form thereby attesting that all information on the form is accurate and true.
Distribution	**The claims coordinator will fax the document to the State Office of Risk Management and retain the original for the agency file.**

AUTHORIZATION FOR RELEASE OF INFORMATION (SORM-16)

Patient:_____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management, 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)_____

Photostatic copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

DATED:_____ SIGNED:_____

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

THANK YOU.

STATE OFFICE *of* RISK MANAGEMENT

STATE OFFICE of RISK MANAGEMENT

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. 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 by initialing your choice

ELECTION 1 *Sick leave must be exhausted before annual leave may be used*

_____ current **sick** leave balance

_____ current **annual** leave balance

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 of hours:* _____).

C. None of my accrued annual leave.

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.

Interval Election

I elect to have my income benefits paid in at the same interval as my wages at the time of my injury.

I understand that I may not change my election after my eighth (8th) day of disability and signing this form. I have read the reverse side of this form, and I fully understand the election I am making.

_____ _____

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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CLAIM NUMBER_____
(If Known)

WITNESS STATEMENT
(SORM-74)

MUST BE TYPED
OR PRINTED

Claimant _____
Employer_____
Date of Injury _____
Statement Taken By _____

Witness Name:_____Age: _____
Residence Address:_____
Home Telephone:_____Work Telephone: _____
Employer:_____
On _____, 20_____, at about _____p.m./a.m., I was in or at (clearly state your own location) _____
_____
when an accident involving the above employee is alleged to have occurred.

(check only one box)

☐ I saw the accident.
The accident occurred in the following manner: _____
_____
_____
_____
_____
_____
Other pertinent information and source: _____
_____
_____

☐ I did not see the accident.
Information given me by (name of person) _____
indicates it occurred as follows: _____
_____
_____
_____
_____
Other pertinent information and source: _____
_____
_____

☐ I know nothing whatsoever about the occurrence.

_____ _____
Signature Date