CAMPUS - WHAT TO DO WHEN THERE IS AN INJURY ON THE JOB

*For Emergencies please direct employee to nearest Emergency Room or Clinic. If possible ensure Employee leaves with **Medical Notice of Reported WC Claim** (Page 2) **Optum Medical First Fill Card** (Page 3 & 4) and contact Risk Management immediately*

- ❑ You must ensure a **First report of Injury** is completed with or with or without the employee's assistance! Go to this link at www.tasbrmf.org and complete **First Report of Injury** and file no later than the next business day. You do not need to log in to complete the First Report of Injury. (Complete with as much information as you have, see instructions on pages 9-15)

- ❑ Have Employee sign **Acknowledgement of Medical Alliance** (Page 5 & 6)

- ❑ If Employee feels he/she may seek medical treatment complete and give the **Verification of Reported WC Claim form** (Page 2) and **Optum First Fill® Program** Information (Page 3 & 4)

- ❑ Have Employee advise whether he/she wishes to use available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form. (Page 7-8)

Email or Fax all signed forms and paperwork by the next business day to:

Eleonora Mujica, Risk Management Specialist
210.444.4556 Phone
210.444.4603 Fax
Eleonora.Mujica@eisd.net Email

Please refer injured employee directly to Eleonora Mujica for any further questions or issues regarding any workers' compensation injury. Alert Risk Management immediately if employee misses any time, returns to work, or if there are any questions or concerns.

To search for primary care physicians in your area go to the Find A Doctor link at the Political Subdivision Medical Alliance (www.pswca.org) website.

NOTE: A First Report of Injury must be filed once employee reports or campus is made aware of any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

Verification of Employment for a Reported Workers' Compensation Injury or Illness
(Please take this form to the doctor for your first medical examination.)

Employee Name ____ Date of Injury ________________________

Date of Birth____ Social Security ________________________

Reported Work Related Injury or Illness: ____

____
_

Edgewood ISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at www.pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
PO Box 2010
Austin, TX 78768-2010
Phone: (800) 482-7276
Fax: (800) 580-6720
Pre-Authorization
Phone: (800) 482-7276 ext. 9907
Fax: (888) 777-8272

Issuing Signature ____________________________________ Title ________________________________

Phone Number____ Date ________________________________

Providers please submit Work Status Reports and all Job Description enquiries to:

Eleonora Mujica, Risk Management Specialist
210.444.4556 Phone
210.444.4603 Fax
Eleonora.Mujica@eisd.net Email

For a full list of Alliance Providers please go to www.pswca.org.

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for TASB Risk Management Fund. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

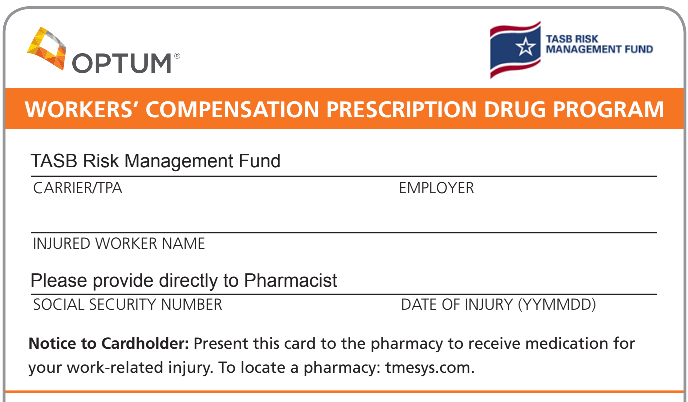
If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426



OPTUM® TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-1614-167

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para TASB Risk Management Fund. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

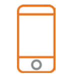
Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta? ¿Necesita ayuda?



1-866-599-5426

OPTUM® | TASB RISK MANAGEMENT FUND

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Management Fund

PORTADORA | EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist

NUMERO DE SEGURO SOCIAL | FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient. This card is not valid for compound medications.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

IMP14-1614-167

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

I have received information that tells me how to get health care under my employer's workers' compensation coverage. If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the Alliance list of doctors designated as treating doctors.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

____ ______/______/______

Signature Date

____

Printed Name

I live at: ____

Street Address

____

City, TX, Zip

Employer Name: Edgewood ISD

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance) Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at www.pswca.org or call your adjuster at 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:______/______/______)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

EMPLOYEE ACKNOWLEDGMENT OF THE ALLIANCE DIRECT CONTRACTING PROGRAM

RECONOCIMENTO DEL EMPLEADO PARA EL PROGRAMA DE CONTRATAR DIRECTAMENTE CON MEDICOS

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escojer de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

Signature (Firma):_____________________________Date (Fecha):____/____/_____

Printed Name (Nombre en imprenta): ____

Address (Direccion de domicilio incluindo cuidad, estado y zip):

____

Employer (Nombre de empleo):Edgewood ISD

Name of Direct Contracting Program (Nombre del programa de contratar doctores directament): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: www.pswca.org o llame a su ajustador al numero: 800-482-7276.

To be completed by the employer only

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury:____/____/____)

DO NOT RETURN THIS FORM TO THE TASB RISK MANAGEMENT FUND UNLESS REQUESTED.

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—ENGLISH VERSION)

Name ____________________________ **Employee number** ___________________

Position ___________________________ **Department/Campus**__________________

This employee is absent from duty because of a job-related illness or injury beginning on *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_________________________________ _________________________________

District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ❑ I choose to use only _____ days of available paid leave at this time.
- ❑ I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.
- ❑ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Edgewood ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation wage benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_________________________________ _________________________________

Employee signature Date

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ ______ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

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FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (NO OFFSET—SPANISH VERSION)

Nombre ______________________________ **Número de empleado** ____________________

Posición ______________________________ **Departamento/campus** ___________________

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en *(fecha de la primera ausencia que se atribuye a enfermedad o lesión)*. Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

________________________________ ________________________________

Firma autorizada de distrito Fecha

Elección del empleado:

Estoy ausenté del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ❑ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.

- ❑ Elijo utilizar todas las licencias con goce de sueldo disponibles. Comprendo que no recibiré los beneficios de ingresos semanales de compensación de los trabajadores hasta que haya acabado toda mi licencia con goce de sueldo o hasta en que la licencia con goce de sueldo no es equivalente a mi sueldo previo a la enfermedad o a la lesión.

- ❑ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Edgewood ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de salario de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

________________________________ ________________________________

Firma del empleado Fecha

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ ______ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

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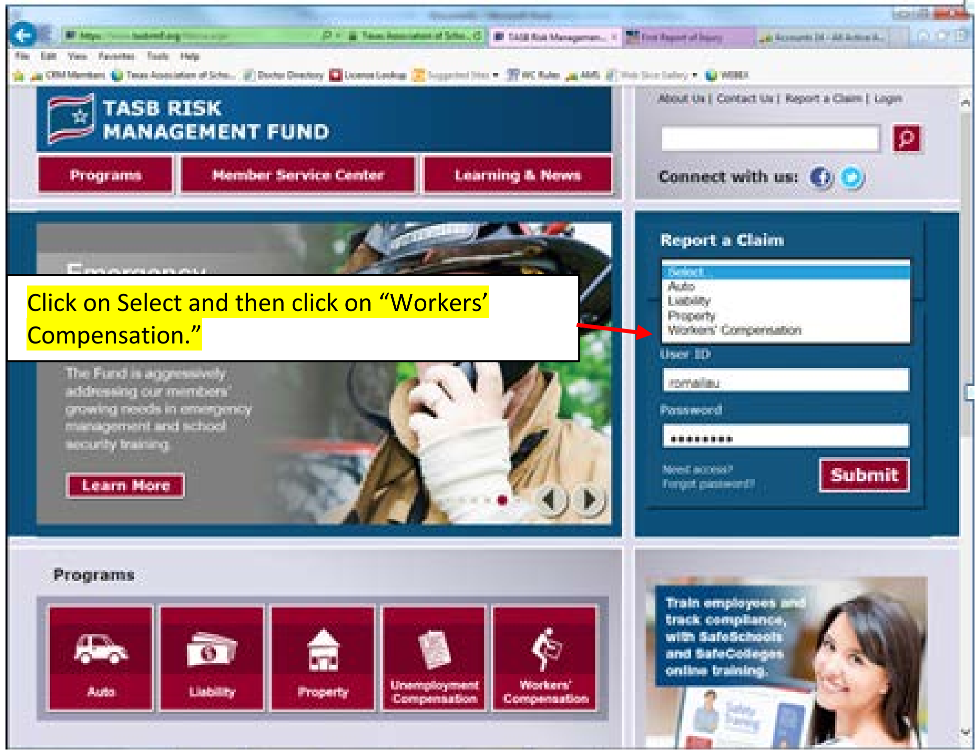
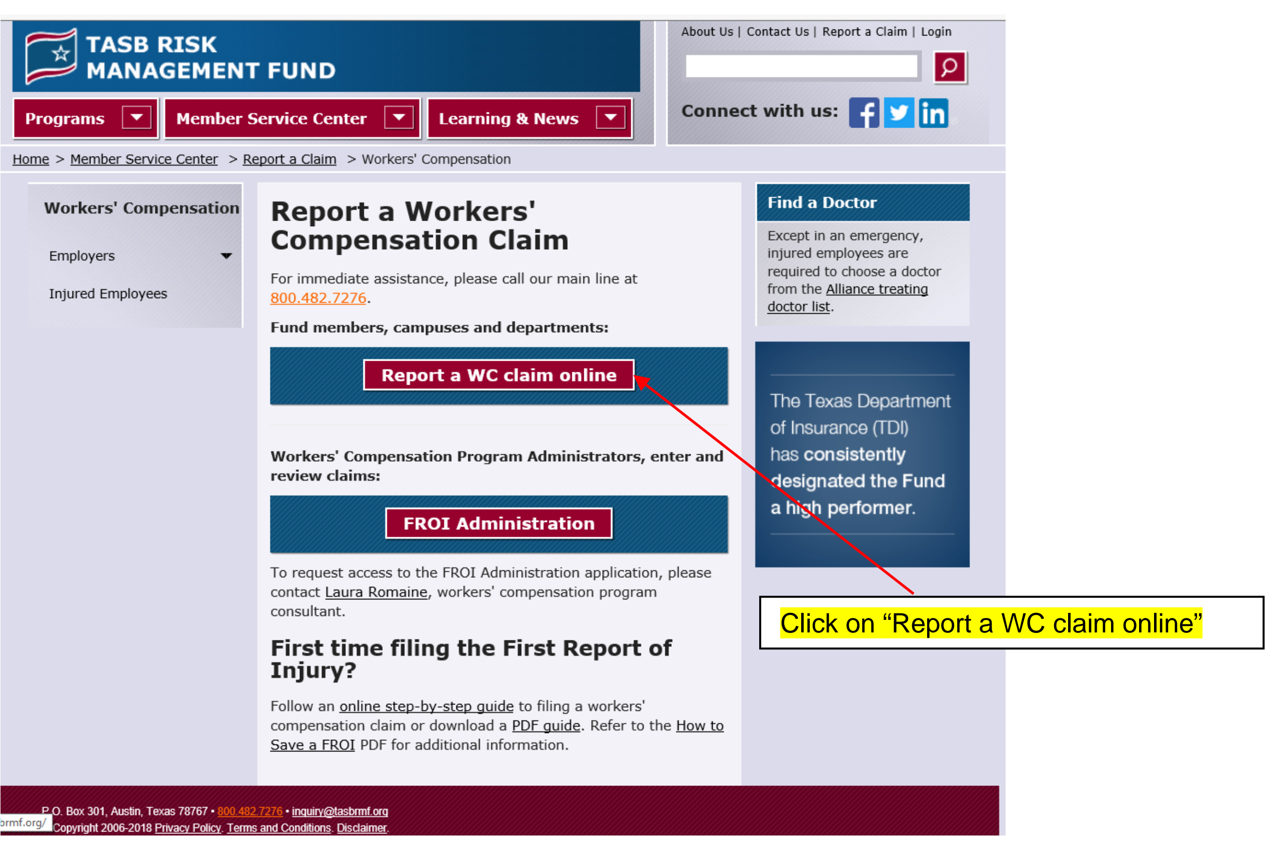
How to File a First Report of Injury

Go to this link. If link isn't working go to www.tasbrmf.org:





You are now at the Online First Report of Injury. You may want to bookmark this page so you can go directly to it in the future:

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Please select your district from the list below then click the submit b

Member Name

Submit

Select your district from the drop down menu and hit submit.

For additional information or questions, please e-mail us.

P.O. Box 2010, Austin, Texas 78767-2010 • 512-467-0222

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TASB RISK MANAGEMENT FUND

The new tasbrmf.org: Simply better

See it now!

TASB Risk Management Fund Homepage

Workers' Compensation

Don't file an amended or corrected copy. If you've submitted and need to make a change, contact Human Resources.

First Report of Injury or Illness

Asterisks denote required information for this report to be properly processed.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

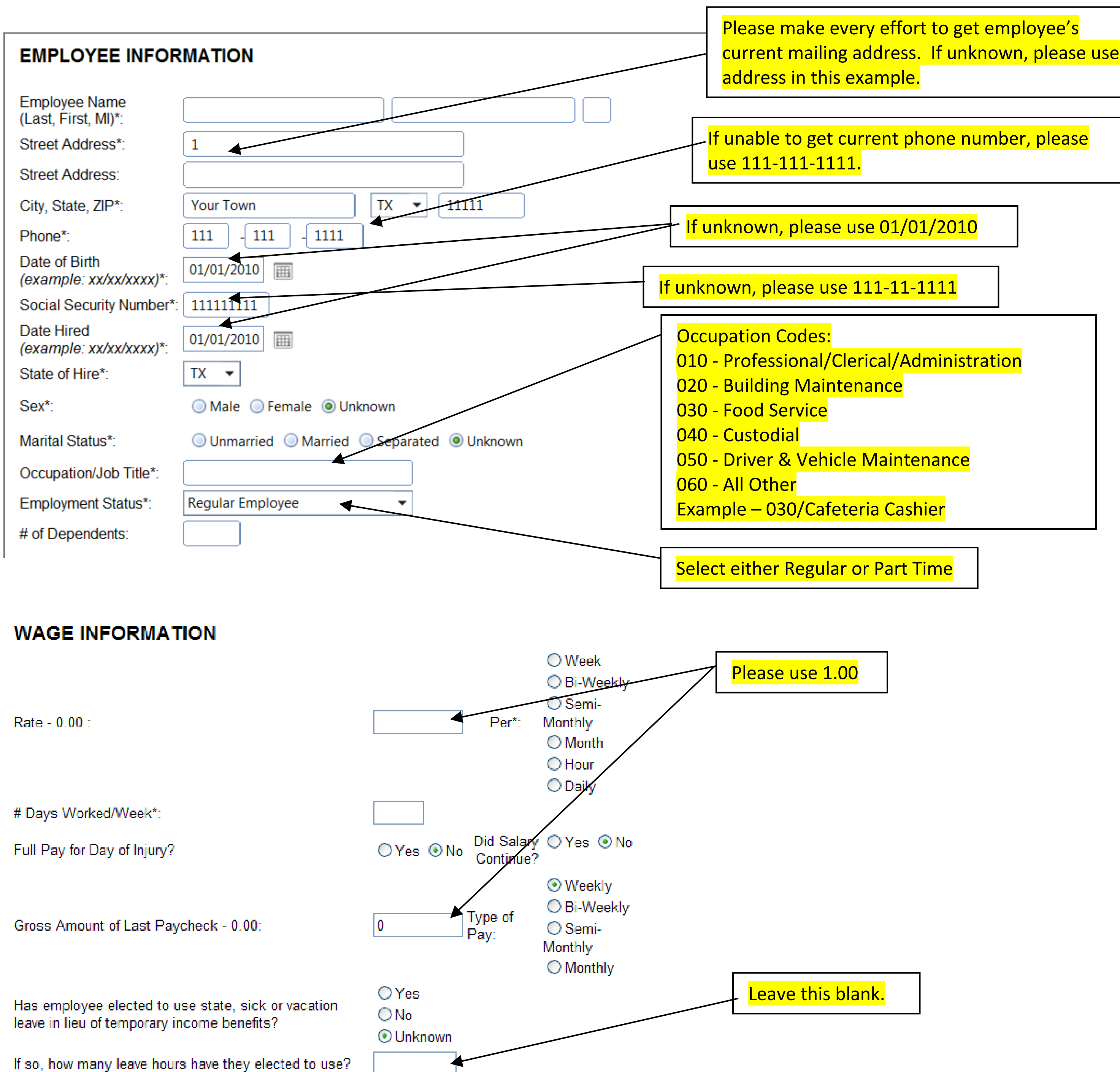
EMPLOYER GENERAL INFORMATION

Employer Name	Education ISD
Street Address Line 1:	123 First Drive
Street Address Line 2:	
City, State, Zip:	Your City, TX 00000
Mailing Address Line 1:	PO Box ABC
Mailing Address Line 2:	
City, State, Zip:	Your City, TX 00000
Tax ID Number:	74-xxxxxxxxx
Phone Number:	(555) 555-1212
SIC Code:	

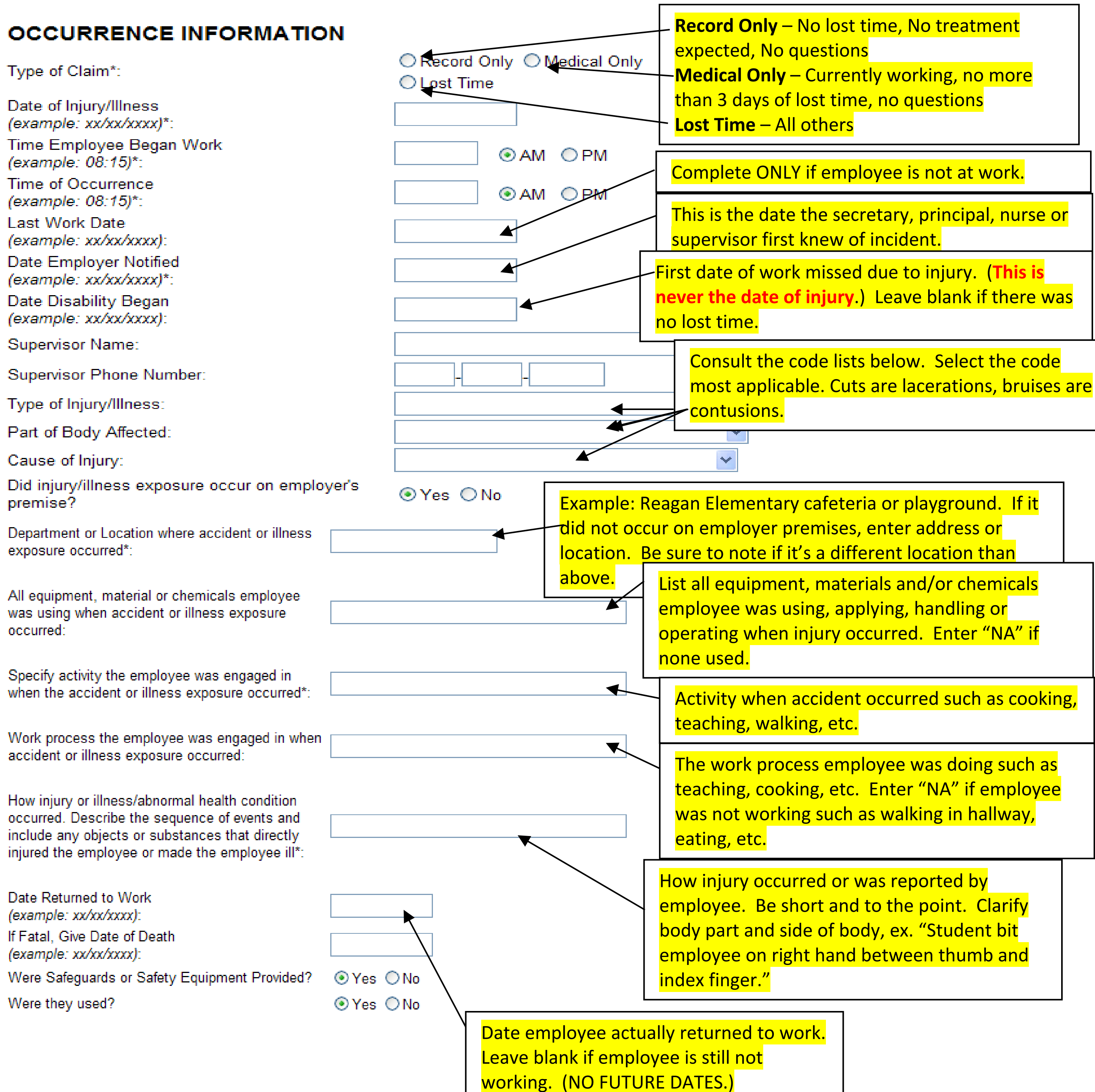
Insured Report Number:

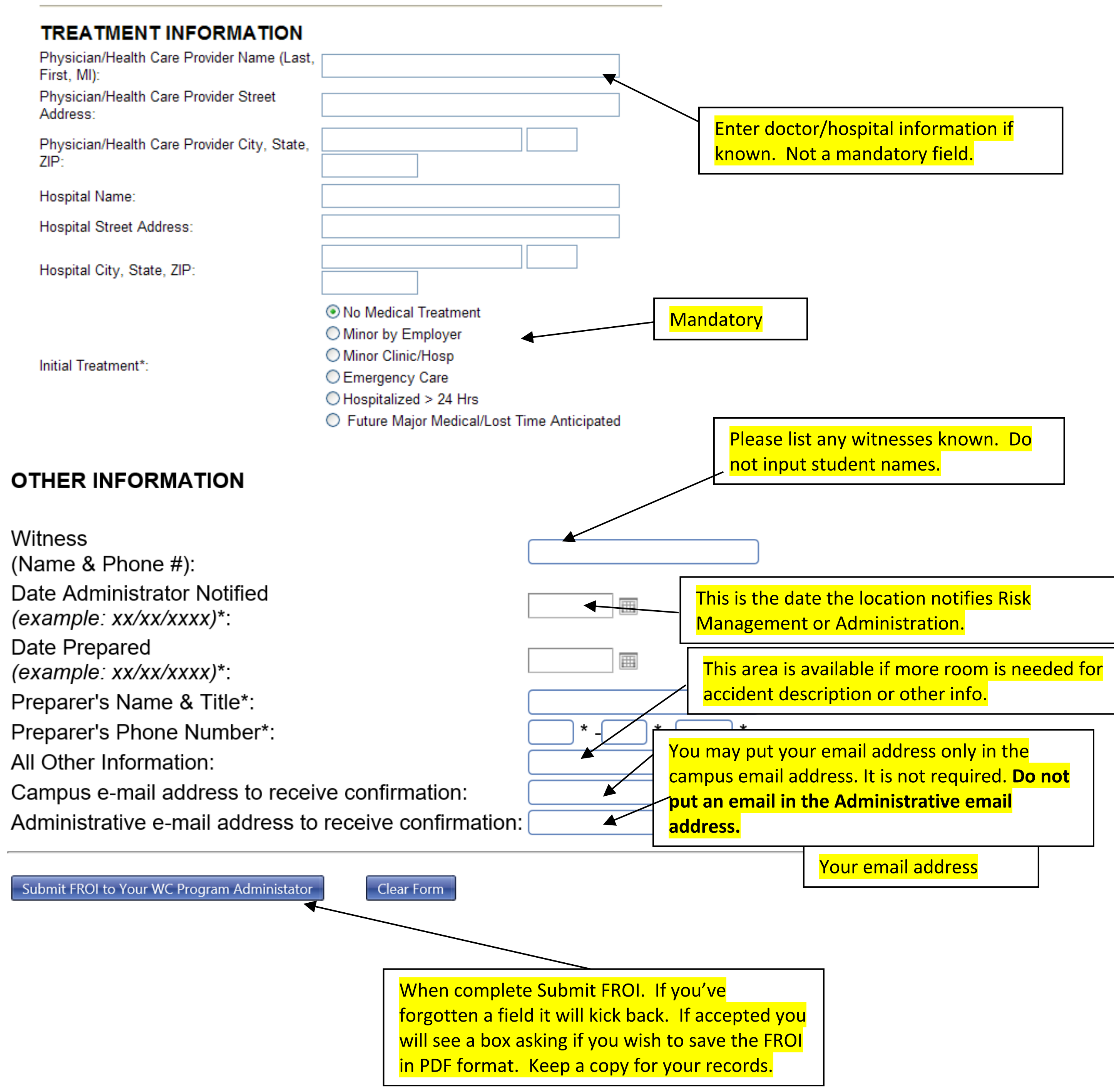
Leave this blank.

Select employee's location or campus code from drop down menu.



EMPLOYEE INFORMATION
Employee Name (Last, First, MI)*:
Street Address*:
1
Street Address:
City, State, ZIP*:
Your Town
TX
11111
Phone*:
111
111
1111
Date of Birth (example: xx/xx/xxxx)*:
01/01/2010
Social Security Number*:
111111111
Date Hired (example: xx/xx/xxxx)*:
01/01/2010
State of Hire*:
TX
Sex*:
Male
Female
Unknown
Marital Status*:
Unmarried
Married
Separated
Unknown
Occupation/Job Title*:
Employment Status*:
Regular Employee
# of Dependents:
Please make every effort to get employee's current mailing address. If unknown, please use address in this example.
If unable to get current phone number, please use 111-111-1111.
If unknown, please use 01/01/2010
If unknown, please use 111-11-1111
Occupation Codes:
010 - Professional/Clerical/Administration
020 - Building Maintenance
030 - Food Service
040 - Custodial
050 - Driver & Vehicle Maintenance
060 - All Other
Example – 030/Cafeteria Cashier
Select either Regular or Part Time
WAGE INFORMATION
Rate - 0.00 :
Per*:
Week
Bi-Weekly
Semi-Monthly
Month
Hour
Daily
Please use 1.00
Days Worked/Week*:
Full Pay for Day of Injury?
Yes
No
Did Salary Continue?
Yes
No
Gross Amount of Last Paycheck - 0.00:
0
Type of Pay:
Weekly
Bi-Weekly
Semi-Monthly
Monthly
Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits?
Yes
No
Unknown
If so, how many leave hours have they elected to use?
Leave this blank.


OCCURRENCE INFORMATION
Type of Claim*:
Record Only
Medical Only
Lost Time
Date of Injury/Illness (example: xx/xx/xxxx)*:
Time Employee Began Work (example: 08:15)*:
AM
PM
Time of Occurrence (example: 08:15)*:
AM
PM
Last Work Date (example: xx/xx/xxxx):
Date Employer Notified (example: xx/xx/xxxx)*:
Date Disability Began (example: xx/xx/xxxx):
Supervisor Name:
Supervisor Phone Number:
Type of Injury/Illness:
Part of Body Affected:
Cause of Injury:
Did injury/illness exposure occur on employer's premise?
Yes
No
Department or Location where accident or illness exposure occurred*:
All equipment, material or chemicals employee was using when accident or illness exposure occurred:
Specify activity the employee was engaged in when the accident or illness exposure occurred*:
Work process the employee was engaged in when accident or illness exposure occurred:
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill*:
Date Returned to Work (example: xx/xx/xxxx):
If Fatal, Give Date of Death (example: xx/xx/xxxx):
Were Safeguards or Safety Equipment Provided?
Yes
No
Were they used?
Yes
No
Record Only – No lost time, No treatment expected, No questions
Medical Only – Currently working, no more than 3 days of lost time, no questions
Lost Time – All others
Complete ONLY if employee is not at work.
This is the date the secretary, principal, nurse or supervisor first knew of incident.
First date of work missed due to injury. (This is never the date of injury.) Leave blank if there was no lost time.
Consult the code lists below. Select the code most applicable. Cuts are lacerations, bruises are contusions.
Example: Reagan Elementary cafeteria or playground. If it did not occur on employer premises, enter address or location. Be sure to note if it's a different location than above.
List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.
Activity when accident occurred such as cooking, teaching, walking, etc.
The work process employee was doing such as teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.
How injury occurred or was reported by employee. Be short and to the point. Clarify body part and side of body, ex. "Student bit employee on right hand between thumb and index finger."
Date employee actually returned to work. Leave blank if employee is still not working. (NO FUTURE DATES.)


TREATMENT INFORMATION
Physician/Health Care Provider Name (Last, First, MI):
Physician/Health Care Provider Street Address:
Physician/Health Care Provider City, State, ZIP:
Hospital Name:
Hospital Street Address:
Hospital City, State, ZIP:
Initial Treatment*:
No Medical Treatment
Minor by Employer
Minor Clinic/Hosp
Emergency Care
Hospitalized > 24 Hrs
Future Major Medical/Lost Time Anticipated
Enter doctor/hospital information if known. Not a mandatory field.
Mandatory
OTHER INFORMATION
Witness (Name & Phone #):
Date Administrator Notified (example: xx/xx/xxxx)*:
Date Prepared (example: xx/xx/xxxx)*:
Preparer's Name & Title*:
Preparer's Phone Number*:
All Other Information:
Campus e-mail address to receive confirmation:
Administrative e-mail address to receive confirmation:
Please list any witnesses known. Do not input student names.
This is the date the location notifies Risk Management or Administration.
This area is available if more room is needed for accident description or other info.
You may put your email address only in the campus email address. It is not required. Do not put an email in the Administrative email address.
Your email address
Submit FROI to Your WC Program Administator
Clear Form
When complete Submit FROI. If you've forgotten a field it will kick back. If accepted you will see a box asking if you wish to save the FROI in PDF format. Keep a copy for your records.

Workers' Compensation

First Report of Injury or Illness

The First Report of Injury for DOE JOHN has been submitted to TASB.

Click here to print the First Report of Injury in IA-1 Format.

(Please allow popup windows from your browser. The IA-1 form will appear in a separate window.)

Download FROI/Excel Format

Download FROI/Text Format

Return to selection screen

P.O. Box 2010, Austin, Texas 78767-2010 • 512-467-0222

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

CARRIER/CLAIMS ADMINISTRATOR

EMPLOYEE/WAGE

OCCURRENCE/TREATMENT

OTHER

FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION ©IAIABC 2002

Nature of Injury

01 No Physical Injury	37 Inflamation	64 Silicosis
02 Amputation	40 Laceration	65 Respirtory Disorders (Fumes)
03 Angina Pectoris	41 Myocardial Infraction	66 Poisoning-Chemical: Not Metals
04 Burn	42 Poisoning-Not OD or Cumulative	67 Metal Poisoning
07 Concusion	43 Puncture	68 Dermatitis
10 Contusion	46 Rupture	69 Mental Disorder
13 Crushing	47 Severance	71 All Other Occupation Disease
16 Dislocation	49 Sprain	72 Loss of Hearing
19 Electric Shock	52 Strain	73 Contagious Disease
22 Enucleation	53 Syncope	74 Cancer
25 Foreign Body	54 Asphyxiation	75 Aids
28 Fracture	55 Vascular Loss	76 VDT - Related Disease
29 Not Used	58 Vision Loss	77 Mental Stress
30 Freezing	59 All Other	78 Carpel Tunnel Syndrome
31 Hearing Loss or Impairment	60 Dust Disease NOC	80 All Other Cumulative Injuries
32 Heat Prostration	61 Asbestosis	90 Mulitiple Inj - Physical Only
34 Hernia	62 Black Lung	91 Multiple Inj - Physical Psych
36 Infection	63 Byssinosis	

Cause of Injury

01 Chemicals	29 Fall/Slip On Same Level	67 Strike/Step Sand, Scrape, Clean
02 Hot Objects or Substances	30 Slipped, Did Not Fall	68 Strike/Step Stationary Obj.
03 Temperature Extremes	31 Fall/Slip Miscellaneous	69 Stepping on Sharpe Object
04 Fire or Flame	32 Fall/Slip: On Ice or Snow	70 Strike/Step Miscellaneous
05 Steam or Hot Fluids	33 Fall/Slip: On Stairs	74 Struck/Injured: Fellow Worker
06 Dust, Gases, Fumes or Vapors	40 Crash of Water Vehicle	75 Struck/Injured: Falling Object
07 Welding Operations	41 Crash of Rail Vehicle	76 Struck/Injured: Tools
08 Radiation	45 Collision With Another Vehicle	77 Struck/Injured: Vehicle
09 Burn: Miscellaneous	46 Collision With Fixed Object	78 Struck/Injured: Moving Machine
10 Caught In/Between Machine(ry)	47 Crash of Airplane	79 Struck/Injured: Obj. Lifted
11 Cold Objects or Substances	48 Vehicle Upset	80 Struck/Injured: Obj. HDLD. OTH
12 Caught In/Between Obj. Handled	50 Motor Vehicle Miscellaneous	81 Struck/Injured:Miscellaneous
13 Caught In/Between/Under, NOC	52 Strain/Injury: Continual Noise	82 Absorbed/Ingested/Inhaled NOC
14 Abnormal Air Pressure	53 Strain/Injury: Twisting	84 Contact With Electric Current
15 Cut/Scrapr by Broken Glass	54 Strain/Injury: Jumping	85 Animal or Insect
16 Cut/Scrape by Hand Tool	55 Strain/Injury: Hold or Carry	86 Explosion or Flare Back
17 Object Being Lifted or Handled	56 Strain/Injury: Lifting	87 Foreign Body in Eye
18 Cut/Scrape Power Tool	57 Strain/Injury: Push or Pull	89 Person in Act of a Crime
19 Cut/Scrape Miscellaneous	58 Strain/Injury: Reaching	90 Not a Physical Cause of Injury
20 Collapsing Materials	59 Strain/Injury: Using Tool/Mach	94 Rubbed/Abraded:Repetitive Motion
25 Fall/Slip From Diff. Level	60 Strain/Injury: Miscellaneous	95 Rubbed/Abraded: Miscellaneous
26 Fall/Slip From Ladder/Scaffold	61 Strain/Injury: Wield or Throw	97 Strain/Injury: Repetitive Motion
27 Fall/Slip From Grease/Liquid	65 Strike/Step Moving Parts	98 Cumulative (All Other)
28 Fall/Slip: Into Openings	66 Strike/Step Obj Lifted/Used	99 Other

Body Part Injured

10 Multiple Head Injury	32 Elbow	51 Hip
11 Skull	33 Lower Arm	52 Upper Leg
12 Brain	34 Wrist	53 Knee
13 Ear(s)	35 Hand	54 Lower Leg
14 Eye(s)	36 Finger(s)	55 Ankle
15 Nose	37 Thumb	56 Foot
16 Teeth	38 Shoulder(s)	57 Toe(s)
17 Mouth	39 Wrist(s) and Hand(s)	58 Great Toe
18 Soft Tissue: Head	40 Multiple Trunk	60 Lungs
19 Facial Bones	41 Upper Back Area (Thoracic)	61 Abdomen Including Groin
20 Multiple Neck Injury	42 Lower Back (Lumbar/Lumbo-Sacral)	62 Buttocks
21 Neck Vertebrae	43 Disc: Trunk	63 Lumber and or Sacral Vertebra
22 Neck Disc	44 Chest, Ribs, Sternum, Soft Tissue	64 Artificial Appliance
23 Spinal Cord (Neck)	45 Sacrum and Coccyx	65 Insufficient Info to Identify
24 Larynx	46 Pelvis	66 No Physical Injury
25 Soft Tissue: Neck	47 Spinal Cord	90 Multiple Body Parts
26 Trachea	48 Internal Organs	91 Body Systems-Single and Multiple
30 Multiple Upper Extremities	49 Heart	99 Whole Body Impairment
31 Upper Arm, Clav. Scapula	50 Multiple Lower Extremities	