

**TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Supervisor's Report Packet for Workers' Compensation**

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Supervisor's Guidelines for Workers' Compensation

Do not delay emergency medical treatment pending completion of packet!

- ◆ **Maintain an ample supply of Employee's and Supervisor's Report Packets.**
- ◆ **If an employee was involved in a work-related incident that could have exposed them to a communicable disease, immediately: (1) have the employee complete a PERS 298, Employee's Report Packet for Workers' Compensation and a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A); and (2) send the employee to the infection control nurse (ICN) for baseline testing. If the employee refuses to go for baseline testing, have the employee sign a statement reflecting that decision.**
- ◆ **Distribute a PERS 298 packet and an applicable job description to any employee who sustains a work-related injury or illness. You may obtain the job description from the human resources representative. Employees shall complete and submit their packets to you during the same shift the injury or illness occurs.**

Ensure the employee reviews the PERS 298 packet and understands the impact the C-80 election form shall have on the employee's monthly paycheck and other benefits before you sign Part B of the PERS 298-2, Employee's Report of Injury or Illness.

If the work-related injury or illness has rendered the employee unable to complete the packet and the employee did not designate someone to act on the employee's behalf, you shall act as the designee, complete the PERS 298-2, Part A and Part B, and submit it to the human resources representative during the same shift the injury or illness occurs.

- ◆ **Remove the DWC FORM-48, "Request for Travel Reimbursement" and provide the notification to the employee for possible future use.**
- ◆ **Audit Employee's Packet for the following:**

PERS 298-2 - Employee's Report of Injury or Illness

- Form is submitted during the same shift the incident occurred.
- Each section in Part A is completed
- Employee signed and dated the form

PERS 298-3 - Employee's Election Regarding Use of Sick and Vacation Leave (C-80 Form)

- Employee has chosen an election in each part, A and B, and signed and dated the form

PERS 298-4 - Authorization for Release of Information (SORM-16 Form)

- Form is completed, signed, and dated

- ◆ **Coordinate with the human resources representative to determine whether the employee is qualified for FML and follow guidelines in the appropriate directive.**
- ◆ **Complete the Supervisor's Packet during the same shift the injury or illness occurs.**

The human resources representative should be able to answer any questions you may have about completing any form in the packet. The following information may help you complete the forms.

PERS 298-2, Employee's Report of Injury or Illness

Complete Part B, Supervisor Acknowledgement of Injury or Illness. Coordinate with the human resources representative to ensure that the sick leave balance on the date of injury or illness is correctly calculated by taking into consideration any sick leave used since the last update to the time screen.

PERS 299-2, Witness Statement

You shall obtain a witness statement from each witness the employee indicated. Do not delay in submitting report packets to the human resources representative because you have not received applicable witness statements. Submit the packet without them and follow up on the statements as soon as possible.

◆ **Submit the Employee packet to the human resources representative.**

Submit witness statements, if applicable, along with the employee's PERS 298 packet to the human resources representative during the same shift the injury or illness occurs.

- You are not relieved of reporting responsibility even if the employee fails to furnish a completed Employee's Packet.

Verify the completeness of the Employee Packet and the Supervisor Packet by comparing each form with those listed on the Contents page of each packet (the top page of each packet).

◆ **If the employee has not notified the human resources representative of the employee's change in status, submit a PERS 299-3, Supplemental Worksheet, to the human resources representative during the same shift of occurrence that the employee:**

- Returns to full duty after being absent due to the work-related injury or illness. Prior to performing job duties, the employee shall submit a DWC FORM-73, Texas Workers' Compensation Work Status Report, or a health care provider's statement releasing the employee to full duty without restrictions if the employee was absent for more than three consecutive workdays or the release indicates restrictions;
- Requires additional days off due to the initial work-related injury or illness. The date is the first full shift of lost time after the employee's latest return to work;
- Is called to service in the uniformed services while on leave without pay;
- Resigns or is separated from employment; or
- Dies.

You are responsible for notifying the human resources representative by the end of the shift of any changes to the employee's status that occur after the initial submission of the Supplemental Worksheet.

◆ **Coordinate with the human resources representative to ensure employee leaves are managed in accordance with applicable TDCJ policies and to ensure qualified absences are appropriately designated as FML.**

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Witness Statement

(Please print or type)

Injured Employee's Full Name: _____ Date of Injury: _____

ALL WITNESSES - COMPLETE THE FOLLOWING

On _____ at about _____ (Circle One) AM or PM I was (clearly state your exact location
Date (mm/dd/yyyy) Time
at the time of the alleged accident) _____

When an accident involving the above employee is alleged to have occurred.

CHECK APPLICABLE BOX:

I observed the accident and it occurred in the following manner: _____

Other pertinent information and source: _____

I did not observe the accident; however, information given to me by (injured employee or witness) indicates it occurred as follows: _____

Other pertinent information and source: _____

I have no knowledge of the occurrence.

Signature _____

Date (mm/dd/yyyy) _____

Complete and return this form to the supervisor **within one workday.**

Distribution:

Reportable: ORIGINAL – Unit or Department Medical File
COPY - Workers' Compensation Program Area, Human Resources Division
COPY - State Office of Risk Management
COPY - Employee

Not Reportable: ORIGINAL - Unit or Department Medical File
COPY - Employee

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Supplemental Worksheet

Change in Employee's Leave Status Relating to a Work-Related Injury or Illness

Name of Injured or Ill: _____ SSN: _____
Last First MI

Unit or Department: _____ HR Region: _____ Date of Injury or Illness: _____
(mm/dd/yyyy)

CHECK APPLICABLE BOX FOR CHANGE IN STATUS:

- Returned to Work on: _____ (Date of First Full Shift Employee Returned to Work)
(mm/dd/yyyy)
 Full Duty or Temporary Alternate or Modified Duty
- Accepted or rejected offer of temporary alternate or modified duty on: _____
(mm/dd/yyyy)
- Additional days of workers' compensation disability beginning: _____ (Date of First Full Shift of Lost Time Due to the Injury or Illness)
(mm/dd/yyyy)
- Exhausted sick/vacation leave balance on: _____ (Only required if employee chose C-80 Part A, Election 1.)
(mm/dd/yyyy)
- Exhausted donated sick leave on: _____ Add exhausted donated sick leave here (PERS 299-3) and on eform (SUPP_WORK)
(mm/dd/yyyy)
- Placed on extended sick leave with pay beginning: _____ through _____
(mm/dd/yyyy) (mm/dd/yyyy)
- Placed on sick leave pool beginning: _____ through _____
(mm/dd/yyyy) (mm/dd/yyyy)
- Placed on: leave without pay (LWOP) workers' compensation or LWOP-FML beginning: _____
(mm/dd/yyyy)

PERS 301, Notification of Medical and Family Leave sent on: _____
(mm/dd/yyyy)

- Change in approved LWOP status
- FML exhausted on: _____
(mm/dd/yyyy)
- Placed on LWOP workers' compensation on: _____
(mm/dd/yyyy)
- Placed on active payroll to run vacation leave on: _____
(mm/dd/yyyy)
- Resignation or separation effective: _____ Reason: _____
(mm/dd/yyyy)
- Death: _____
(mm/dd/yyyy)

If report is being submitted more than one workday after the change in status, provide a reason for late reporting: _____

SUPERVISOR (if applicable):

(Please Print) Last Name First Name MI Title

Signature Date: (mm/dd/yyyy)

HUMAN RESOURCES REPRESENTATIVE:

(Please Print) Last Name First Name MI Signature Date (mm/dd/yyyy)

Distribution:

ORIGINAL – Unit or Department Medical Files

COPY - Email or fax to the Workers' Compensation Program Area, Human Resources Division within one workday of change in status

COPY - Risk Management Coordinator

COPY - Employee

PERS 299-3 (01/21)