TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Possible Work-Related Exposure to a Communicable Disease

Employee Name and Mailing Address	Employee Payee ID
Name:	
Mailing Address:	**Date of Possible Exposure**
City, State, and Zip Code:	

If you contract a disease as a result of this work-related exposure, you may file a claim for workers' compensation. To qualify for workers' compensation benefits, the law requires that you provide:

- A written statement that includes the date and circumstances of the exposure; and
- Documentation that you were tested within 10 calendar days after the date of the exposure to establish baseline test results. Texas Department of Criminal Justice (TDCJ) personnel do not have access to these test results.

For your records, attached is a PERS 298, Employee's Report Packet for Workers' Compensation. A copy of these reports shall be maintained in your unit or department medical file.

A possible work-related exposure to a communicable disease is not reportable as a workers' compensation illness unless you later contract the disease. If you should contract a disease because of this possible exposure, you may initiate a report through this office. Since we have no access to your test results, you are required to provide documentation of the test you had within 10 days after the exposure to accompany the report.

If you prefer not to initiate a report through this office, you may also report the incident directly to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by calling 1-800-252-7031 or contacting a local TDI-DWC field office.

Employee Statement: _____

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Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

HUMAN RESOURCES REPRESENTATIVE:

_____ _____

Name (Printed) Signature Date (mm/dd/yyyy)

_____

Phone Number

Attachment(s)
Copy: Unit or Department Medical File