

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
PD-45 (rev. 5), “WORKERS’ COMPENSATION AND RETURN TO WORK PROGRAM”
JANUARY 1, 2021

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TEXAS DEPARTMENT
OF
CRIMINAL JUSTICE

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SUPERSEDES: PD-45 (rev. 4)
September 1, 2015

EXECUTIVE DIRECTIVE

SUBJECT: WORKERS' COMPENSATION AND RETURN TO WORK PROGRAM

AUTHORITY: 29 C.F.R. § 825.125; Tex. Educ. Code § 19.009(g); Tex. Gov't Code §§ 493.001, 493.006(b); Tex. Health & Safety Code §§ 81.003(1), 85.116; Tex. Lab. Code §§ 408.025(a-1), 415.008, 415.021, 501.001-.051; Tex. Occ. Code §§ 301.001-.657; 25 Tex. Admin. Code §§ 96.101 (Dept. of State Health Services, Definitions), 97.13 (Dept. of State Health Services, Death of a Person with Certain Communicable Diseases); 28 Tex. Admin. Code §§ 45.10 (Tex. Dept. of Insurance, Div. of Workers' Compensation, Employer's Report of Injury and Disease), 109.1 (Tex. Dept. of Insurance, Div. of Workers' Compensation, State Agencies: General Provisions), 122.3 (Tex. Dept. of Insurance, Div. of Workers' Compensation, Exposure to Communicable Diseases; Reporting and Testing Requirements for Emergency Responders), 251.207 (State Office of Risk Management, Requirements for Submitting Form TWCC-1S); State Office of Risk Management, "Risk Management for Texas State Agencies"; Correctional Managed Health Care Policy B-14.5; BP-02.08, "Statement of Internal Controls"

APPLICABILITY: Texas Department of Criminal Justice (TDCJ)

EMPLOYMENT AT WILL CLAUSE:

This directive **does not** constitute an employment contract or a guarantee of continued employment. The TDCJ reserves the right to change the provisions of this directive at any time.

Nothing in this directive limits the executive director's authority to establish or revise human resources policy. This directive guides the operations of the TDCJ and **does not** create a legally enforceable interest for employees or limit the executive director's, deputy executive director's, or division directors' authority to terminate an employee at will.

POLICY:

The TDCJ shall administer a Workers' Compensation and Return to Work Program in a fair and consistent manner in compliance with the *Texas Workers' Compensation Act* and without regard to race, color, religion, sex (gender), national origin, age, disability, or genetic information. The TDCJ has zero tolerance for all forms of employment discrimination. No employee or other individual shall be subjected to retaliation for opposing or reporting employment discrimination in the Workers' Compensation and Return to Work Program.

DEFINITIONS:

The following terms are defined for the purpose of this policy and are not intended to be applicable to other policies or procedures.

“As Soon As Practicable” is as soon as possible and practical, taking into account all of the facts and circumstances in the individual case.

“Business Hours” are 8:00 a.m. - 5:00 p.m., Monday through Friday.

“Common Use Area” is an area in a unit or department accessible to all employees assigned to the unit or department during each shift, such as the break room or lobby area.

“Communicable Disease” is an illness occurring through the transmission of an infectious agent or its toxic products from a reservoir to a susceptible host, either directly as from an infected person or animal, or indirectly through an intermediate plant or animal host, a vector, or the inanimate environment. Examples of communicable diseases include hepatitis B, human immunodeficiency virus (HIV), and tuberculosis (TB).

“Compensable Injury” is a work-related injury for which compensation is payable under the *Texas Workers' Compensation Act*.

“Disability” is the inability, because of a compensable injury, to obtain and retain employment at wages equivalent to the pre-injury wage. “Disability” under state workers' compensation law is defined differently than “disability” under the *Americans with Disabilities Act (ADA)*, because the state workers' compensation law serves a different purpose.

“Employee” is any person employed by the TDCJ on a full-time, part-time, or temporary basis.

“Exposure” is specific eye, mouth, other mucous membrane, non-intact skin, or needle contact with blood or other potentially infectious materials resulting from the performance of an employee's duties.

“Health Care” includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services, but does not include vocational rehabilitation. Health care also includes: (1) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of a

doctor; (2) physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a doctor; (3) psychological services prescribed by a doctor; (4) the services of a hospital or other health care facility; (5) a prescription drug, medicine, or other remedy; and (6) a medical or surgical supply, appliance, brace, artificial member, or prosthesis, including training in the use of the appliance, brace, member, or prosthesis.

“Health Care Provider” is a doctor of medicine or osteopathy, podiatrist, dentist, clinical psychologist, optometrist, chiropractor, licensed acupuncturist, nurse practitioner, nurse midwife, or clinical social worker who is performing within the scope of their practice as defined under state law, any health care provider recognized under the Texas Employees Group Benefits Program, a Christian Science practitioner listed with the First Church of Christ, Scientist in Boston, Massachusetts, or an advanced practice registered nurse or physician assistant with authority delegated from a treating doctor to complete and sign a work status report regarding an injured employee’s ability to return to work.

“Health Care Provider’s Statement” (HCPS) is a written statement from an attending health care provider identifying the description associated with the injury or illness and the expected duration of the injury or illness. It is possible for a written statement from the employee’s attending health care provider to meet the requirements to be considered both an HCPS and a release to return to work. However, an HCPS does not automatically meet the requirements to be a release to return to work.

“Job Description” is a TDCJ document defining the job summary, essential functions, minimum qualifications (education, experience, knowledge, and skills), and additional requirements with or without reasonable accommodations in reference to a specific position within the TDCJ. The “Additional Requirements With or Without Reasonable Accommodation” section identifies the physical and mental characteristics necessary to perform the essential functions of that position, the job location, special conditions, and equipment used in performing the essential functions.

“Occupational Disease” is a disease arising out of and in the course of employment causing damage or harm to the physical structure of the body, including a repetitive trauma injury. The term includes a disease or infection naturally resulting from the work-related disease. The term does not include an ordinary disease of life to which the general public is exposed outside of employment, unless that disease is incident to a compensable injury or occupational disease.

“Release to Return to Work” is a written statement from an employee’s attending health care provider that identifies a date the employee may return to work and clearly indicates: (a) restrictions or limitations and whether they are permanent, long-term, intermittent, or temporary; or (b) no restrictions or limitations. Any statement without reference to restrictions or limitations shall be considered an unconditional release. It is possible for a written statement from the employee’s attending health care provider to meet the requirements to be considered both a release to return to work and an HCPS. However, a release to return to work does not automatically meet the requirements to be an HCPS. A release to return to work for an employee who has been absent due to a work-related injury or illness may consist of a DWC FORM-73, Texas Workers’ Compensation Work Status Report.

“Spouse” means a person to whom a person is legally married.

“Temporary Duty Assignment” is a temporary alternate duty assignment or a temporary modified duty assignment. A temporary duty assignment shall be for a maximum period of 12 consecutive workweeks per work-related injury or illness, even if the employee works intermittently during the assignment. A temporary duty assignment allows an eligible employee to perform duties and tasks within the temporary physical or mental limitation(s) established by the employee’s health care provider and shall only include duties considered non-correctional duties. The employee’s rate of pay shall be the same rate the employee was receiving at the time the work-related injury or illness was sustained or incurred.

- (1) “Temporary Alternate Duty Assignment” refers to duties assigned through the Return to Work Program to a correctional employee who incurred a work-related injury or illness. During the assignment, the employee shall dress in attire appropriate for a non-correctional employee and have a schedule the same as a non-correctional employee.
- (2) “Temporary Modified Duty Assignment” refers to duties assigned through the Return to Work Program to a non-correctional employee who incurred a work-related injury or illness.

“Work-Related Injury or Illness” is damage or harm to the physical structure of the body arising out of and in the course of employment. The term includes an occupational disease.

“Workday” means a day when an employee is normally scheduled to work.

“Workers’ Compensation Program Area” is the program area within the Human Resources Division responsible for: (1) coordinating the processing of all Workers’ Compensation transactions through the State Office of Risk Management (SORM) within a specified time frame; (2) providing technical assistance to TDCJ staff; and (3) reporting statistical information.

“Working Retiree” is an active TDCJ employee who concurrently holds a retirement status through the Employees Retirement System of Texas. A working retiree is not eligible for withdrawal from the Sick Leave Pool or extended sick leave.

“Workweek” is a period of seven consecutive calendar days with the beginning of the workweek being on the same calendar day the temporary alternate or modified duty assignment is scheduled to begin. For example: If a temporary alternate or modified duty assignment is scheduled to begin on a Wednesday, the period from Wednesday through Tuesday counts as one workweek of the assignment.

DISCUSSION:

An employee who fails to comply with the procedures within this directive, unless it is not practicable under the particular circumstances to do so despite the employee's diligent, good faith efforts, may be subject to disciplinary action in accordance with PD-22, "General Rules of Conduct and Disciplinary Action Guidelines for Employees," or administrative separation in accordance with PD-24, "Administrative Separation."

I. Medical Attention and Health Care

A. Initial Medical Attention from Unit Medical Staff

Unit medical staff may provide necessary medical attention, including initial evaluation and treatment, to a TDCJ employee who is injured or contracts an illness in the performance of the employee's duties. Unit medical staff shall not provide follow-up evaluations or treatment for a work-related injury or illness nor routine medical services for a non-work-related injury or illness.

B. Health Care

1. The *Texas Workers' Compensation Act* provides that an employee who sustains a compensable injury or illness is entitled to all health care required by the nature of the injury or illness as and when needed. This may include health care that:
 - a. Cures or relieves effects naturally resulting from the compensable injury or illness;
 - b. Promotes recovery; or
 - c. Enhances the ability of the employee to return to or retain employment.
2. Except in an emergency, all health care shall be approved or recommended by the employee's attending doctor.

II. Reports of Work-Related Injuries or Illnesses

- A. An employee who has sustained or incurred a work-related injury or illness shall not be subjected to retaliation for filing a claim for workers' compensation benefits in good faith or for exercising any other rights provided by the *Texas Workers' Compensation Act*.
- B. All reports of work-related injuries or illnesses allegedly sustained in the course and scope of employment shall be completed and distributed as outlined in this directive.

- C. A work-related injury or illness becomes reportable to the SORM when one of the following occurs:
1. The employee affected by the work-related injury or illness has been absent from work for at least one full scheduled work shift;
 2. Medical expenses have been incurred;
 3. The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) requests a report;
 4. A work-related fatality occurs and the injury or illness was not self-inflicted;
 5. The employee claims to have contracted a contagious or infectious disease due to a work-related exposure; or
 6. The employee has an occupational disease the TDCJ knows about, even if the employee has not missed any work.
- D. All records related to an employee's medical condition are confidential under state and federal statutes and shall be protected accordingly.

III. Workers' Compensation Benefits

- A. The SORM determines if an employee is eligible to receive workers' compensation benefits.
- B. Benefits are governed by state law and administered by the TDI-DWC. Compensation payments are set at the rate specified by law on the date of injury or illness.
- C. The SORM may reduce the employee's temporary income benefits if an employee rejects a bona fide offer of a temporary alternate or modified duty assignment through the Return to Work Program that the employee is reasonably capable of performing, given the physical condition of the employee and the geographic accessibility of the position to the employee.
- D. As directed by statute, benefits are provided to the appropriate beneficiaries upon an employee's death resulting from a work-related injury or illness.

IV. Return to Work Program

A. Participation Requirements

An employee who has sustained or incurred a work-related injury or illness shall participate in the Return to Work Program in accordance with this directive.

B. Employee with a Disability

An employee's participation in the Return to Work Program shall not be construed as recognition by the TDCJ that the employee has a disability as defined by the ADA and does not constitute an accommodation under the ADA.

C. Other Temporary Assignments

Temporary alternate or modified duty assignments in accordance with this directive do not remove an employee from the employee's job position, and shall not count toward the six months an employee may be temporarily assigned to another position in accordance with PD-79, "Employee Transfers, Reassignments, and Temporary Assignments."

V. Fraud

A. An employee who commits fraud by making a false or misleading material statement, misrepresenting or concealing a material fact, fabricating, altering, concealing, or destroying a document, or conspiring to do any of these acts may be subject to administrative and criminal penalties.

B. Individuals with knowledge of suspected workers' compensation fraud may provide a signed written report regarding such information to the Workers' Compensation Program Area for submission to the SORM. The Workers' Compensation Program Area shall provide a copy of the signed written report to the Risk Management Department.

PROCEDURES:

I. Breakage of Eyeglasses or Hearing Aids

When an employee's eyeglasses or hearing aids are broken as a result of involvement in an offender altercation and there is no additional loss of visual or auditory capacity, the damage is considered damage to personal property and is not compensable under workers' compensation. The employee may obtain reimbursement from the TDCJ in an amount not to exceed \$500 for the replacement of eyeglasses and corresponding eye exam and in an amount not to exceed \$1,000 for the repair or replacement of hearing aids. A unit assigned employee shall contact the unit supply officer to receive the

reimbursement. A non-unit assigned employee shall submit a request for reimbursement to the employee's immediate supervisor.

II. Communicable Disease Exposure

A. Employee Responsibilities

1. To qualify for workers' compensation benefits, state law requires an employee who claims a possible work-related communicable disease exposure to provide a written statement to the TDCJ documenting the date and circumstances of the exposure and documenting the fact that within 10 calendar days after the date of the exposure the employee had a test result that indicated an absence of infection.

Therefore, an employee who believes they may have been exposed to a communicable disease, such as hepatitis B, HIV, TB, or other communicable disease, as a result of the employee's work-related duties shall immediately:

- a. Complete a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A), and a PERS 298, Employee's Report Packet for Workers' Compensation (Attachment C), which includes a PERS 298-2, Employee's Report of Injury or Illness;
 - b. Provide the completed PERS 305 and PERS 298 packet to the employee's supervisor; and
 - c. Contact the unit infection control nurse (ICN) at the nearest unit to ensure the incident qualifying as an exposure is further documented.
2. If the employee later claims to have contracted a disease due to the documented work-related exposure, the employee shall not be required to complete another PERS 298-2. The employee may contact TDI-DWC directly or report the illness through the employee's unit or department. The employee shall reference the original incident report.
 3. If an employee claims to have contracted a disease due to a previous specific work-related exposure that was not documented within 10 calendar days of the possible exposure incident, the employee may:
 - a. Contact the TDI-DWC directly; or

- b. Report the illness through the employee's unit or department by completing a PERS 298 packet. The employee should include as much information as possible concerning the original incident.

B. Supervisor Responsibilities

If an employee was involved in a work-related incident that could have exposed them to a communicable disease such as hepatitis B, HIV, or TB, the supervisor shall immediately:

1. Ensure the employee completes or has completed a PERS 305 and a PERS 298 packet;
2. Send the employee to the ICN for possible testing. If the employee refuses to go for possible testing, have the employee sign a statement reflecting that decision;
3. Complete and sign Part B of a PERS 298-2;
4. Ensure a PERS 299-2, Witness Statement (Attachment D), is completed for each individual identified as a witness on the employee's notice; and
5. Submit all forms to the human resources representative by the end of the shift during which the possible work-related communicable disease exposure occurred.

C. Baseline and Follow-Up Testing

The ICN shall determine whether the incident qualifies as an exposure. Baseline testing shall be offered to the employee regardless of whether the incident qualifies as an exposure.

1. Incident Does Not Qualify as an Exposure

If the ICN determines the incident does not qualify as an exposure, follow-up testing shall not be authorized. If the employee wishes to have follow-up testing, the employee may contact the local or regional health department for available testing services or may be tested by the employee's personal health care provider at the employee's expense. Testing by personal health care providers may or may not be covered by the employee's health insurance carrier or health maintenance organization (HMO).

2. Incident Qualifies as an Exposure

If the ICN determines the incident qualifies as an exposure, the unit physician or midlevel practitioner with the assistance of the ICN or designee shall thoroughly evaluate, document, and provide first aid, appropriate prophylactic, or emergency treatment for the exposure and related injuries or illness. If the employee's scope of injuries or illness exceeds the facility's capabilities to provide definitive treatment or if the exposure occurs when a physician or midlevel provider is not present, the employee may be referred to the nearest emergency facility capable of managing the injuries or illness.

If applicable, post-exposure counseling shall be provided to the employee and the employee's spouse or significant other by a medical provider trained in HIV counseling as required by state law and TDCJ policy. Follow-up testing shall be offered to the employee.

D. Human Resources Representative Responsibilities

The human resources representative shall:

1. Maintain the documentation related to the exposure in the employee's unit or department employee medical file until the incident becomes reportable (see Discussion, Section II.C.); and
2. Upon the incident becoming reportable, take the steps in Procedures, Section III.C.2.

III. Work-Related Injuries or Illnesses

A. Employee Responsibilities

When an employee sustains a work-related injury or illness in the course and scope of employment, the employee shall immediately advise the supervisor and complete a PERS 298, Employee's Report Packet for Workers' Compensation (Attachment C), to document the work-related injury or illness and elections regarding use of accrued leave. The employee shall take these steps even if the employee does not want to file a workers' compensation claim.

1. Submission of a PERS 298 Packet

The employee shall return the completed PERS 298 packet to the supervisor by the end of the shift during which the work-related injury or illness occurred. If the employee is unable to complete the PERS 298 packet and cannot designate someone to act on the employee's behalf, the employee's supervisor shall complete the PERS 298-2, Employee's

Report of Injury or Illness, and forward to the human resources representative.

2. Changes to Elections Regarding Use of Accrued Leave

Changes to elections regarding use of accrued leave may only be made in accordance with the instructions on the PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A) or Employee's Other Time Election C-80 (Part B), which is included in the PERS 298 packet. These changes only affect subsequent periods of absence resulting from the work-related injury or illness occurring after the employee returns to work and signs a new form. The changes are not retroactive.

Changes to elections regarding use of accrued leave shall require the submission of a new and additional PERS 298-3.

3. Changes to Workers' Compensation Status

An employee shall inform the human resources representative of any changes affecting the employee's workers' compensation status as soon as practicable, for example receiving a release to return to full duty, requiring additional days off, being called to service in the uniformed services, or separating employment.

4. Workers' Compensation Health Care Providers

The SORM partners with a Workers' Compensation Health Care Network (HCN) to provide an employee access to approved workers' compensation health care providers. Information regarding the TDCJ's current HCN and instructions on locating an approved health care provider can be found in the PERS 298 packet or by calling an adjuster with the SORM. The Employee Network Notification Packet and the PERS 607, Workers' Compensation Network Acknowledgement Form have been incorporated into the PERS 298 packet (Attachment C).

5. TDI-DWC Work Status Report

a. If the employee incurs medical expenses, the employee shall have the health care provider complete a DWC FORM-73 or HCPS upon the following:

- (1) The employee's initial visit to the health care provider; or
- (2) A subsequent visit resulting in a change in treatment or work restrictions, such as an increase or decrease in work restrictions, or a release to return to work.

- b. The employee shall provide the DWC FORM-73 or HCPS to the human resources representative via hand carry, email, or fax in accordance with PD-46, "Medical and Parental Leave."

6. Mental or Physical Restrictions

- a. An employee may be eligible for an ADA accommodation if:
 - (1) The employee receives a DWC FORM-73 showing maximum medical improvement from the health care provider identifying a physical or mental restriction; and
 - (2) The restriction substantially limits the employee from performing an essential function of the employee's job.
- b. The employee may notify the accommodation coordinator, Employee Relations, Human Resources Division in accordance with PD-14, "Americans with Disabilities Act and Employment of Persons with a Disability." The fact that an employee is awarded workers' compensation benefits, has a disability as defined by the *Texas Workers' Compensation Act*, or is assigned an impairment rating by a physician under the workers' compensation system does not automatically establish that the employee is protected by the ADA.

7. Return to Work

- a. If an employee is returning to work after an initial visit to a health care provider that resulted in an absence of more than three consecutive workdays, the employee shall provide a health care provider's release to return to work via hand carry, email, or fax in accordance with PD-46, "Medical and Parental Leave."
- b. The employee shall provide any other required documentation to support the leave period via hand carry, email, or fax in accordance with PD-46, "Medical and Parental Leave."

B. Supervisor Responsibilities

Supervisors shall be familiar and comply with the guidelines set out in this directive and in the PERS 299, Supervisor's Report Packet for Workers' Compensation (Attachment D). Supervisors shall also be familiar with the PERS 298 packet and the potential impact the elections identified on the PERS 298-1, Employee's Guidelines for Workers' Compensation, may have on the employee's

monthly paycheck and other benefits. In the case of correctional employees, the shift supervisor shall assume the supervisor's responsibilities.

1. Report Packets

Supervisors shall maintain an ample supply of PERS 298 packets and PERS 299 packets.

2. Employee Submits the PERS 298 Packet

Upon receipt of a completed PERS 298 packet from the employee, the supervisor shall:

- a. Ensure the employee has reviewed the PERS 298 packet, completed all forms, and understands how the elections identified on the PERS 298-3 impact the employee's monthly paycheck and other benefits;
- b. Complete and sign Part B of PERS 298-2;
- c. Ensure a PERS 299-2, Witness Statement, is completed for each individual identified as a witness on the employee's notice; and
- d. Submit all forms to the human resources representative by the end of the shift during which the work-related injury or illness occurred.

3. Employee Unable to Complete the PERS 298 Packet

The supervisor shall be responsible for completing the PERS 298-2 and submitting the documents to the human resources representative if:

- a. The supervisor is aware of a work-related injury or illness for which the employee did not complete or was unable to complete the required paperwork by the end of the shift during which the work-related injury or illness occurred; and
- b. The employee was unable to designate someone to act on the employee's behalf.

4. Leave Management

A supervisor shall 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 family and medical leave (FML).

5. Employee's Return to Work or Other Change in Status

- a. A supervisor shall allow an employee to return to work if the employee has been off more than three consecutive workdays and provides a release to return to work.
- b. Upon becoming aware of any change in the employee's status by means other than notice from the human resources representative, the supervisor shall complete a PERS 299-3, Supplemental Worksheet, and submit the PERS 299-3 to the human resources representative's office by the end of the shift during which the supervisor becomes aware that the employee:
 - (1) Is returning to 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 or HCPS releasing the employee to full duty without restrictions if the employee was absent for more than three consecutive workdays;
 - (2) Was on leave without pay;
 - (3) Is returning to work after the employee's initial visit to the health care provider;
 - (4) Requires additional days off due to the initial work-related injury or illness;
 - (5) Is called to service in the uniformed services while on leave without pay;
 - (6) Resigns or is separated from employment; or
 - (7) Dies.

C. Human Resources Representative Responsibilities

1. Program Administration

Human resources representatives are responsible for the overall administration of the Workers' Compensation and Return to Work Program procedures within the unit or department. These responsibilities include the following:

- a. Maintaining and making available to supervisors an ample supply of PERS 298 packets, PERS 299 packets, and PERS 305 forms;

- b. Upon being notified of a work-related injury or illness, verifying the supervisor provided the employee with a PERS 298 packet, and a copy of the employee's applicable job description;
- c. Being thoroughly familiar with the impact the elections identified on the PERS 298-1 may have on an employee's paycheck and benefits;
- d. Ensuring supervisors and employees are trained in the reporting of workers' compensation claims and indicating that employees fully understand the impact the elections identified on the PERS 298-1 may have on an employee's paycheck and benefits;
- e. Communicating with the employee the importance of completing the PERS 298-3 (Part A);
- f. Ensuring employees indicate they understand the various leave options;
- g. Communicating with an injured or ill employee on a regular basis during the employee's recuperation from a compensable work-related injury or illness, until the employee is able to return to work;
- h. Complying with the provisions in this directive and the provisions of TDCJ leave policies;
- i. Posting required workers' compensation posters in common use areas; and
- j. Maintaining all documentation relating to an employee's work-related injury or illness in the employee's unit or department medical file.

2. Reporting for TDCJ Employees Assigned to the Unit or Department

The human resources representative is responsible for the following:

- a. Ensuring appropriate documentation is completed within one workday after any work-related injury or illness occurs.
- b. Providing the appropriate safety officer with a copy of the PERS 298-2 and a copy of any PERS 299-2 within one workday to assist the safety officer in the investigation of the workers' compensation incident and claim.

- c. Generate a Workers' Compensation Primary First report (WORK_COMP) within one workday after the work-related injury or illness is reported.
- d. Submitting, via fax, email, or hand delivery, the appropriate documentation, including the cover letter (Attachment B) to the Workers' Compensation Program Area and the SORM within one workday after the work-related injury or illness becomes reportable.
- e. If parts A and B of the PERS 298-3 were not submitted with a PERS 298 packet, immediately contact the employee to complete these forms within one workday to avoid automatic "Election 1" by the SORM.
- f. Generating a Workers' Compensation Change Status (WORK_SUPP) e-form, no later than one workday after the employee has a reportable change in status, such as:
 - (1) Returns to duty after being absent due to the work-related injury or illness;
 - (2) Requires additional days off due to the initial work-related injury or illness;
 - (3) Exhausts sick leave and vacation leave balance due to the work-related injury or illness, which only applies to employees who choose Election 1 on Part A of the PERS 298-3;
 - (4) Is placed in approved leave without pay status due to the work-related injury or illness;
 - (5) Has a change in approved leave without pay status due to the work-related injury or illness;
 - (6) Has received donated sick leave, approval of extended sick leave with pay, or withdrawals from the sick leave pool due to the work-related injury or illness;
 - (7) Is called to service in the uniformed services while on leave without pay;
 - (8) Resigns or is separated from employment; or
 - (9) Dies.

3. Reporting for Windham School District (WSD) Employees

When an employee who works for the WSD sustains a work-related injury or illness, the TDCJ unit or department human resources representative where the employee is assigned shall coordinate with the WSD Human Resources Department to ensure the applicable guidelines in Procedures, Section III.C.2 are followed. The unit or department human resources representative shall forward a copy of all documentation related to the work-related injury or illness to the WSD Human Resources Department for maintenance.

4. Reporting for Employees Attending Pre-Service or In-Service Training

When an employee sustains a work-related injury or illness while attending pre-service or in-service training, the pre-service or in-service human resources representative shall follow the applicable guidelines in Procedures, Section III.C.2.

5. Denial of Claims

A notification from the SORM is sent to both the Workers' Compensation Program Area and the employee via first class mail if the employee's claim is denied. Upon receipt of notification from the Workers' Compensation Program Area that the SORM has denied liability for an employee's claim or has indicated an employee's lost time should no longer be considered work-related, the human resources representative shall attempt to contact the employee to assist the employee in adjusting the employee's leave status.

IV. Return to Work Program Temporary Alternate or Modified Duty Assignments

A. General Provisions

1. The identification, assignment, and management of temporary alternate or modified duty assignments shall be handled on a case-by-case basis as warranted by the business necessity of the TDCJ.
2. Temporary alternate or modified duty assignments shall be physically located at the same unit or department as the employee's assignment at the time the employee sustained or incurred the work-related injury or illness or at a unit or department within the same pooled area. See Return to Work Program Pooled Areas (Attachment E).
3. A temporary alternate or modified duty assignment shall begin on the first day the employee reports to work for the assignment. An employee may work intermittently during the assignment.

4. The assignment shall continue for a maximum period of 12 consecutive workweeks per work-related injury or illness, even if the employee:
 - a. Experiences additional absences due to injury or illness; or
 - b. Is certified to return to full duty by the health care provider, then experiences additional absences due to injury or illness and is subsequently released to the temporary duty assignment once again.
5. The assignment shall end and not be extended when the 12 consecutive workweeks expire.
6. If an employee incurs a subsequent unrelated injury or illness while performing the temporary alternate or modified duty assignment, the assignment shall not be extended to accommodate the subsequent unrelated injury or illness. An employee shall return to full duty from the injury or illness that resulted in the temporary alternate or modified duty assignment prior to being offered another temporary alternate or modified duty assignment for a subsequent unrelated injury or illness.

B. Warden or Department Head Responsibilities

The warden or department head shall identify temporary alternate or modified duty assignments to facilitate an employee's return to work based on the TDCJ's business necessity. Identification of temporary alternate or modified duty assignments shall be coordinated with the supervisor and human resources representative. If no temporary alternate or modified duty assignments are available within the warden's or department head's unit or department, the warden or department head shall contact other units or departments within the same pooled area to determine availability of such assignments.

C. Human Resources Representative Responsibilities

Human resources representatives are responsible for the overall administration of the Return to Work Program within the unit or department. Human resources representatives shall be thoroughly familiar with the impact the Return to Work Program may have on an employee's status of employment, paycheck, employment benefits, and workers' compensation benefits.

The employee's human resources representative shall also be responsible for the following:

1. Upon receipt of the DWC FORM-73 or HCPS authorizing a temporary alternate or modified duty assignment, the human resources representative shall:

- a. Coordinate with the warden or department head to identify a temporary alternate or modified duty assignment;
- b. Identify the begin date for the temporary alternate or modified duty assignment based on the DWC FORM-73 or HCPS; and
- c. Attempt to contact the employee by telephone and read the PERS 376, Offer of Temporary Alternate or Modified Duty Assignment (Attachment F), to the employee. If the human resources representative is unable to reach the employee via telephone or if the employee rejects the initial assignment over the phone, the human resources representative shall mail the PERS 376 to the employee, via certified mail, return receipt requested.

If within three workdays of receipt of the certified mailed PERS 376 an employee fails to either contact the human resources representative or return the signed form indicating acceptance or rejection to the human resources representative, the failure to do so shall be considered an official rejection of the assignment.

2. Upon an employee's verbal or written acceptance of the temporary alternate or modified duty assignment, the human resources representative shall:
 - a. Instruct the employee to report to the human resources representative on the employee's first day of assignment; and
 - b. Notify the employee's supervisor and the temporary alternate or modified duty assignment supervisor, if different from the employee's supervisor, of the employee's acceptance of the assignment.
3. When the employee reports to the human resources representative on the first day of the temporary alternate or modified duty assignment, the human resources representative shall:
 - a. Ensure the employee indicates acknowledgement of the assignment period by signing the PERS 376 in the appropriate space;
 - b. Immediately notify the employee's supervisor and the temporary alternate or modified duty assignment supervisor, if different from the employee's supervisor;
 - c. Forward a copy of the signed PERS 376 to the employee's supervisor and the temporary alternate or modified duty

assignment supervisor, if different from the employee's supervisor, to the Workers' Compensation Program Area, and to the SORM, via fax or email; and

- d. Continue to be responsible for any of the employee's human resources related services while the employee is performing the temporary alternate or modified duty assignment, including reporting of time, even if the employee's temporary alternate or modified duty assignment is at another unit within the pooled area.
4. Upon the employee's official rejection of the assignment, such as a signed PERS 376 indicating rejection, or failure to respond to the PERS 376 mailed via certified mail, the human resources representative shall immediately notify the employee's supervisor and the Workers' Compensation Program Area. If applicable, the human resources representative shall retain the original PERS 376 and forward by email one copy of the signed PERS 376 to the employee's supervisor and the Workers' Compensation Program Area. If the employee did not return a signed PERS 376, the human resources representative shall document the employee's failure to do so on the PERS 376, retain the original documentation, and fax or email a copy to the SORM, the employee's supervisor, and the Workers' Compensation Program Area.
 5. Within one workday of receipt of the employee's official acceptance or rejection of an Offer of Temporary Alternate or Modified Duty Assignment, the human resources representative shall generate a Workers' Compensation Change Status (WORK_SUPP) e-form. If the email system is not available, a copy of the completed Supplemental Worksheet should be faxed to the Workers' Compensation Program Area, Human Resources Headquarters.
 6. At the end of the temporary alternate or modified duty assignment, the human resources representative shall:
 - a. Have the employee sign the original PERS 376, indicating the employee's acknowledgement of the expiration of the assignment.
 - b. Immediately forward a copy of the signed PERS 376 to the employee's supervisor.
 - c. If the employee has been certified by the health care provider to return to full duty, return the employee to the same position the employee held at the time the work-related injury or illness was sustained or incurred.

- d. If the employee has not been certified by the health care provider to return to full duty, place the employee in the appropriate leave status in accordance with TDCJ leave policies or separate the employee as applicable.
 - e. Generate a Workers' Compensation change in status (WORK_SUPP) no later than one workday after the change in status.
7. The human resources representative shall maintain all original documentation pertaining to the temporary alternate or modified duty assignment in the employee's unit or department medical file.

D. Employee Responsibilities

1. An employee may receive a verbal offer for a temporary duty assignment or a written PERS 376 from the human resources representative. If an employee receives a verbal offer, the employee shall inform the human resources representative of acceptance or rejection of the assignment at the time the offer is made.

If the employee rejects a verbal offer or the employee cannot be reached by phone, a PERS 376 shall be mailed to the employee via certified mail, return receipt requested. Within three workdays of receipt of the PERS 376, the employee shall either contact the human resources representative to verbally accept the assignment or return the signed PERS 376 to the human resources representative indicating acceptance or rejection of the assignment. If an employee fails to contact the human resources representative or return the PERS 376 indicating acceptance or rejection within three workdays of receipt, the assignment shall be considered officially rejected.

2. If an employee accepts a temporary alternate or modified duty assignment, the employee shall report to the human resources representative on the first day of the assignment and sign the PERS 376. The employee shall perform the duties of the temporary alternate or modified duty assignment for a maximum period of 12 consecutive workweeks per work-related injury or illness or until the employee is certified by the health care provider to return to full duty, whichever occurs first.
3. If the temporary alternate or modified duty assignment supervisor is not the employee's regular supervisor, the employee shall have the temporary alternate or modified duty assignment supervisor approve and sign the employee's time sheets and fax, email, or hand carry the signed time sheets to the employee's human resources representative.

4. If the employee receives certification by the health care provider to return to full duty, the employee shall notify the human resources representative of the change in status as soon as practicable and before reporting to work.
5. If the employee has not been certified by the health care provider to return to full duty at the completion of the temporary alternate or modified duty assignment, the employee shall coordinate leave through the human resources representative in accordance with TDCJ leave policies.

Bryan Collier
Executive Director

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: _____

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



Texas Department of Criminal Justice

Bryan Collier
Executive Director

Date Faxed/Emailed: _____

THE STATE OFFICE OF RISK MANAGEMENT

Workers' Compensation Division

Fax #: (512) 370-9025

Email: coordforms@sorm.state.tx.us

Human Resources Headquarters

Fax #: (936) 437-4140

Email: workcomp@tdcj.texas.gov

RE: NAME: _____

SSN: _____

DATE OF INJURY OR ILLNESS: _____

The original report for the above injury or illness is attached. Your office was initially notified by the Texas Department of Criminal Justice's Workers' Compensation department via entry into the SORM on-line system.

Sincerely,

Signature

Human Resources Representative: _____

Telephone: _____

Unit/Department Name: _____

Unit/Department Address: _____

Attachments:

Copy: Unit or Department Medical File

Our mission is to provide public safety, promote positive change in offender behavior, reintegrate offenders into society, and assist victims of crime.

Human Resources Division
2 Financial Plaza, Ste. 600, Huntsville, Texas 77340
www.tdcj.texas.gov

Texas Department of Criminal Justice
Employee's Report Packet for Workers' Compensation

CONTENTS

PERS 298-1, Employee's Guidelines for Workers' Compensation

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

PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A) and Employee's Other Time Election C-80 (Part B)

PERS 298-4, Authorization for Release of Information (Form No. SORM-16 9-98)

PERS 298-5, Employee's Acknowledgement of Responsibilities Relating to Work-Related Injury or Illness

DWC FORM-48, Request for Travel Reimbursement

myMatrixx Workers' Compensation Prescription Information

PERS 607, Workers' Compensation Network Acknowledgement

CareWorks Employee Notice of Network Requirements

DWC FORM-73, Texas Workers' Compensation Work Status Report – This form shall be provided by the human resources representative.

Texas Department of Criminal Justice Employee's Guidelines for Workers' Compensation

COMPLETION OF THE EMPLOYEE'S PACKET

- ◆ Complete the forms located in the PERS 298, Employee's Report Packet for Workers' Compensation any time you sustain a work-related injury or illness (whether or not you plan on filing a workers' compensation claim) or when you believe you may have been exposed to a communicable disease as a result of your work-related duties. If you believe you may have been exposed to a communicable disease, you are also required to complete a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A) and contact infection control nurse (ICN) at the nearest unit for baseline testing.

It is your responsibility to review the PERS 298 packet and understand the impact that the elections on the PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 (Part A), and Employee's Other Time Election C-80 (Part B) may have on your state benefits. You should contact your supervisor or human resources representative for additional information to ensure that you understand the impact of the C-80 elections.

- ◆ Submit the completed PERS 298 packet to your supervisor by the end of the same shift the injury or illness occurs.
- ◆ Designate a person to act on your behalf if you are unable to complete the PERS 298 packet, or your supervisor shall complete the PERS 298-2 for you.
- ◆ General guidance for each form in the PERS 298 packet:

PERS 298-2, Employee's Report of Injury or Illness: Complete each blank in Part A (1-12) and sign and date the form before you submit it to your supervisor, who shall complete Part B.

PERS 298-3, Employee's Election Regarding Use of Sick and Vacation Leave C-80 and Employee's Other Time Election C-80 (Parts A and B): You may change your elections to Part A until you have reached your eighth day of workers' compensation disability. The eight days do not have to be consecutive. A change to Part B may only be made when you return to work. Changes shall only affect subsequent periods of absence resulting from the work-related injury or illness that occur after you sign the revised form. The changes shall not be retroactive. **As previously stated, it is your responsibility to understand how the elections you choose may impact your pay and other benefits as described under the heading "Effect of C-80 Elections on Benefits."** A description of these elections follows:

C-80 Part A: Addresses the use of accrued sick and vacation leave and establishes the initial compensation payment start date. You may not receive workers' compensation income benefits while using accrued sick leave, including sick leave pool, donated sick leave, extended sick leave, or accrued vacation leave. There shall be a waiting period of seven calendar days before workers' compensation benefits begin. To the extent these benefits are available, Part A allows you to:

Election 1: Exhaust all accrued sick leave and then all or part of accrued vacation leave before receiving any workers' compensation payments.

Election 2: Not use any accrued sick leave or vacation leave, thereby freezing your sick and vacation leave balances.

Accrued compensatory, holiday, and overtime may be used during the waiting period of seven calendar days as indicated in Part B. If you do not elect to use sick leave during the seven-day waiting period and you are on leave for your work-related injury or illness for 28 days or more, you shall receive an additional payment to reimburse you for the waiting period.

C-80 Part B: After Part A sick and vacation leave elections are made, Part B elections determine how accrued compensatory, holiday, and overtime are to be used during your absence due to the work-related injury or illness. To the extent you are eligible for these benefits, Part B allows you to:

Election 1: Exhaust all eligible accrued time in the following order: compensatory, holiday, and overtime.

Election 2: Not use any accrued compensatory, holiday, or overtime, thereby freezing all balances until after returning to work.

Election 3: Use a portion of accrued time, thereby freezing remaining balances until returning to work.

If you elect to freeze your accrued compensatory and holiday time and because of your injury or illness are unable to use the time before it expires, the time shall not be restored.

If you elect to freeze your accrued time and upon exhaustion of the 180 days leave without pay-medical (LWOP-Medical) period you have not physically returned to work, you shall be placed on the active payroll until all accrued compensatory and holiday time is exhausted. After all accrued compensatory and holiday time is exhausted, you shall then be separated from employment and your accruals of overtime and vacation leave shall be handled in accordance with PD-49, "Leaves Other than Medical and Parental."

- PERS 298-4, Authorization for Release of Information (SORM-16): Complete, sign, and date.
- DWC FORM-48, Request for Travel Reimbursement: Please read the information provided to determine if you have travel expenses that are eligible for reimbursement.
- DWC FORM-73, Texas Workers' Compensation Work Status Report instructions.

EFFECT OF C-80 ELECTIONS ON BENEFITS

While unable to work due to the work-related injury or illness, your benefits are affected. Refer to the following information and to the table entitled C-80 Election Combinations of this attachment for assistance in choosing the elections that you consider best for you.

◆ LEAVE

For continued employment with the TDCJ, you are required to comply with PD-46, "Medical and Parental Leave," or PD-49, "Leaves Other than Medical and Parental." You are required to provide a DWC FORM-73 or health care provider's statement (HCPS) before you return to work if, as a result of the work-related injury or illness you were absent for more than three days or your HCPS or DWC FORM-73 indicates restrictions.

When submitting a PERS 24, TDCJ Leave Request, attach an HCPS for the requested leave period. The requested leave period shall not exceed six months, or the date the health care provider has indicated you may return to work.

Leave with Pay: While using accrued sick, vacation, compensatory, holiday, or overtime, you are on leave with pay. You may also be eligible to receive additional benefits, to include:

Extended Sick Leave: You are required to have at least five years of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the onset or initial diagnosis of the current injury or illness, have applied for withdrawals from the sick leave pool, not be a working retiree, and not have used 12 workweeks of extended sick leave in the past five years. All accrued time balances shall be exhausted.

Sick Leave Pool: You are required to meet the eligibility criteria in PD-50, "Sick Leave Pool," including the requirement to have at least 12 months of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the time of the current injury or illness, have donated a minimum of eight hours to the sick leave pool during the current fiscal year, not be a working retiree, and you shall not have withdrawn from the sick leave pool during the current fiscal year. All accrued time balances shall be exhausted.

Donated Sick Leave: Any employee may donate any amount of the employee's accrued sick leave to another employee who (1) is a TDCJ employee; and (2) has exhausted all paid entitlements, including donated sick leave received before sick leave pool approval, and be subject to loss of compensation from the state. Donated sick leave shall be used in accordance with the procedures in PD-46, "Medical and Parental Leave." You are required to have exhausted all accrued sick leave, including any time you may be eligible to withdraw from the sick leave pool, prior to receipt of any donated sick leave hours. You may not donate your donated sick leave hours.

If you choose to freeze any portion of your accrued time balances, you will not be eligible to apply for extended sick leave or sick leave pool.

If you choose to freeze any portion of your accrued sick leave, you will not be eligible to receive short- or long-term disability benefits.

If you choose to freeze any portion of your accrued sick leave, you will not be eligible to receive any donated sick leave.

Leave without Pay-Medical (LWOP-Medical): Before your leave with pay is exhausted, you shall request LWOP-Medical in accordance with PD-46, "Medical and Parental Leave."

Family and Medical Leave (FML): The human resources representative shall determine whether your absence due to a work-related injury or illness should be designated as FML, either with pay or without pay. You may qualify for FML if you:

- Have at least 12 months of state service;
- Suffer from a serious health condition;
- Have worked at least 1,250 hours during the previous year; and
- Have not used more than 12 workweeks of FML in the previous 12 months.

◆ **INITIAL VISIT TO A HEALTH CARE PROVIDER/RETURN TO WORK**

Regardless of when the injury or illness occurred, you are required to notify your supervisor as soon as you incur medical expenses resulting from the work-related injury or illness or you are off work a full shift due to the work-related injury or illness, so that your supervisor can notify the human resources representative of your change in status.

You are responsible for ensuring that the health care provider who provides medical services has been approved by the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to treat CareWorks Network workers' compensation injured employees. You may call your adjuster at the State Office of Risk Management (SORM) or TDI-DWC, or access the TDI-DWC website at www.tdi.texas.gov to ensure that your health care provider treats workers' compensation injured employees.

Upon your initial visit to a CareWorks Network health care provider, you shall provide the CareWorks Network health care provider with a copy of the job description that was provided to you by your supervisor. The health care provider should provide you with a completed DWC FORM-73. (The health care provider shall have a DWC FORM-73 on hand, because the TDI-DWC requires health care providers to use this form.)

You are required to provide the DWC FORM-73 or an HCPS from your initial visit to your human resources representative in accordance with PD-46, "Medical and Parental Leave," via hand carry, email, or fax. The DWC FORM-73 or HCPS shall indicate one of the following:

- 1) You qualify to participate in a temporary alternate or modified duty assignment.

If you qualify for a temporary alternate or modified duty assignment, a verbal or written offer shall be made by the human resources representative. A rejection shall be reported to the SORM and any applicable workers' compensation benefits may be readjusted. You should continue to coordinate leave through your human resources representative in accordance with TDCJ policies.

2) Based on the restrictions indicated, you are not eligible to return to work at the present time.

If you are absent more than three consecutive days, you shall be required to also provide your supervisor with a PERS 24, TDCJ Leave Request, and an HCPS in accordance with PD-46, "Medical and Parental Leave."

◆ **SUBSEQUENT VISITS TO THE HEALTH CARE PROVIDER**

If a subsequent visit to the health care provider results in a change in treatment or work restrictions, you are required to provide, via hand carry, email, or fax, a subsequent DWC FORM-73 or HCPS to your human resources representative within one workday of the subsequent visit.

◆ **RETURN TO WORK WITH ACCOMMODATIONS**

Employees with physical or mental restrictions may apply for accommodations in accordance with PD-14, "Americans with Disabilities Act and Employment of Persons with a Disability."

◆ **WORKERS' COMPENSATION**

Workers' compensation benefit payments replace only a percentage of your regular pay; however, the benefit payments are not subject to social security, withholding taxes, or the mandatory retirement contribution to the Employees Retirement System (ERS) of Texas.

You **cannot** receive workers' compensation payments while using accrued sick leave, sick leave pool, donated sick leave, extended sick leave, or vacation leave.

You **can** receive workers' compensation payments while using accrued overtime, holiday, or compensatory time if you elect to use this time on the C-80 elections.

◆ **GROUP INSURANCE**

Disability (if applicable):

Payments begin after a waiting period of 30 days (short-term disability) or 90 days (long-term disability) after the date lost time began or after accrued sick leave is exhausted, whichever is greater, or after extended sick leave, sick leave pool, or donated sick leave payments cease. Payments are reduced by the amount of your workers' compensation payments.

Long-term disability applies only if an approved attending health care provider certifies that you are totally disabled.

Health Coverage: You shall receive a detailed letter from the ERS, if you are required to make payments. Payments shall be made by cashier's check or money order.

While on leave with pay: The state contribution to your insurance continues, and your portion of the premium shall be deducted from your paycheck.

While on LWOP designated as FML: The state contribution continues, so you shall only be responsible for paying your portion of the premium.

While on LWOP not designated as FML: No state contribution shall be paid; therefore, you shall be responsible for the entire premium if you are in LWOP status that is not designated as FML for a complete month. However, your workers' compensation payment amount increases to compensate for the decrease in the state contribution for the employee's health insurance only.

If you do not pay your group insurance premium, your coverage shall be cancelled effective the last day of the month for which no payment has been made. To reinstate cancelled coverage, apply through your human resources representative as soon as you return to work.

◆ **OTHER BENEFITS**

If you are participating in voluntary benefit programs, such as 457 Deferred Compensation Plan, 401(k) Texa\$aver Plan, Texas Tuition Promise Fund, TexFlex, or Service Purchase Installment Program, payroll deductions shall continue in effect until your TDCJ paycheck is no longer sufficient to cover your deductions unless you request that the deductions be discontinued at an earlier date.

◆ **PAYMENT OF MEDICAL BILLS AND PRESCRIPTIONS**

Inform the attending health care provider, hospital, and pharmacist that medical claims and prescriptions are to be filed as workers' compensation. Except for emergency care, the attending health care provider should request pre-certification through the SORM.

If the claim is approved, liability for payment of medical services, prescriptions, etc. shall be assumed by the SORM. Your human resources representative or the Workers' Compensation Program Area, Human Resources Division, can verify that a work-related injury or illness has occurred, but neither can accept liability for payment. Claims for payment of medical bills or prescriptions shall be considered and paid by the SORM only after an itemized bill is submitted to the SORM which includes the employee's name, social security number, and date of injury. Employees are responsible for providing copies of health care provider's statements to adjusters as required.

The attending health care provider should direct any questions about workers' compensation and mail all bills and reports to:

State Office of Risk Management
P.O. Box 13777
Austin, Texas 78711-3777
Phone 512-475-1440

◆ **PROBLEMS WITH CLAIMS**

Any problems you may have with claims should be referred to your SORM claims adjuster at the address and telephone number indicated above.

◆ **DENIED CLAIMS**

If your claim is denied by the SORM and you are unable to return to work, you shall contact your human resources representative to determine your leave options. Contact your local TDI-DWC office or write your claims adjuster at the address indicated for the SORM regarding your right to appeal a denied claim.

◆ **FRAUD**

If you knowingly or intentionally perform any of the following acts in an attempt to obtain workers' compensation benefits, you may have committed an administrative violation that is punishable by an administrative penalty not to exceed \$25,000 per day per occurrence:

- Make a false or misleading material statement.
- Misrepresent or conceal a material fact.
- Fabricate, alter, conceal, or destroy a document.
- Conspire to commit an act as listed above.

◆ **DENTAL**

Should you require dental services for your injury that is not due to an emergency, you shall obtain pre-authorization from the SORM prior to services being provided.

◆ **MULTIPLE EMPLOYMENT**

If you have other employment in addition to the TDCJ, you may be eligible to report those wages to increase your weekly benefit. Please contact the SORM directly at 512-475-1440 for additional eligibility information.

C-80 ELECTION COMBINATIONS

Part A	Part B	Impact of Elections on Pay and Benefits
1	1	<p>Elects to use all accrued sick leave then all or part of vacation leave and other time.</p> <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4. - May apply for extended sick leave and sick leave pool, if eligible, prior to all time being depleted. - May receive donated sick leave hours.
1	2	<p>Elects to use all accrued sick leave then all or part of vacation leave and freezes other time.</p> <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued sick and vacation leave is depleted. See Note 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Note 3. - Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted. - Ineligible to receive donated sick leave since paid leave entitlements are not depleted.
1	3	<p>Elects to use all accrued sick leave then all or part of vacation leave and use a portion of other time.</p> <ul style="list-style-type: none"> - Pay and insurance coverage continues until sick and vacation leave is depleted and other time reaches specified levels. See Notes 1 and 2. - Workers' compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted. - Ineligible to receive donated sick leave since paid leave entitlements are not depleted.
2	1	<p>Elects not to use accrued sick or vacation leave. Use other time until balances are depleted.</p> <ul style="list-style-type: none"> - Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since sick or vacation leave is not depleted. - Ineligible for short- or long-term disability benefits. - Ineligible to receive donated sick leave since paid leave entitlements are not depleted.
2	2	<p>Elects not to use accrued sick or vacation leave and freezes other time.</p> <ul style="list-style-type: none"> - Pay and insurance coverage stops. See Note 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Note 3. - Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted. - Ineligible for short- or long-term disability benefits. - Ineligible to receive donated sick leave since paid leave entitlements are not depleted.
2	3	<p>Elects not to use accrued sick or vacation leave and use a portion of other time.</p> <ul style="list-style-type: none"> - Pay and insurance coverage continues until other time reaches specified levels. See Notes 1 and 2. - Workers' compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4. - Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted. - Ineligible for short- or long-term disability benefits. - Ineligible to receive donated sick leave since paid leave entitlements are not depleted.

Note 1: "Other time" includes compensatory, holiday, and overtime.

Note 2: You are required to apply for LWOP-Medical prior to the depletion of all accrued time. If in LWOP status, you shall be responsible for the payment of all insurance premiums. If on FML, the state paid portion of the insurance premium continues, but you shall continue to be responsible for payment for any coverage, such as family, beyond that.

Note 3: If eligible for short-term disability insurance, payments do not begin until after 30 days or sick leave is depleted, whichever is greater. You cannot draw short-term disability payments and use sick leave simultaneously.

Note 4: You cannot draw workers' compensation benefits while using accrued sick or vacation leave.

HUMAN RESOURCES
REPORTABLE () Y () N
LOST TIME () Y () N

Texas Department of Criminal Justice
Employee's Report of Injury or Illness

PART A: EMPLOYEE OR DESIGNEE (CLEARLY PRINT THE FOLLOWING INFORMATION)

- Employee's Payroll Name: (Last, First, MI) _____
Current Mailing Address: _____ Email: _____
City: _____ County: _____
State: _____ Zip Code: _____
Social Security Number: _____ Home Phone Number: _____
Date of Birth (mm/dd/yyyy): _____ Gender: _____
- Marital Status (check one): Married Widowed Single Separated Divorced
- Number of Dependent Children: _____ Name of Spouse: _____
- Did you receive treatment from a health care provider for this injury or illness? (check one) Yes No
Did you incur medical expenses? Yes No
- If medical expenses were incurred, provide the following information:
Attending Physician's Name: _____ Hospital: _____
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
- Date of injury or illness: _____ Time of injury or illness: _____ (check one) AM PM
Are you a third shift employee: Yes No If third shift, date shift actually began: _____
- Unit or department where the injury or illness occurred: _____
- Nature of injury or illness (cut, bruise, etc.): _____
Part(s) of body affected: _____
- Detailed description of how the injury or illness occurred: _____

- Were you performing normal job duties? (check one) Yes No
Work site where injury or illness occurred (stairs, dock, etc.): _____
- Cause of injury or illness (fall, tool, machine, offender, etc.): _____
- Full name(s) of witness(es): _____

I certify that the above injury or illness was not caused by my intent, willful misconduct, or neglect. I acknowledge receipt and understanding of the Workers' Compensation Employee's Guidelines.

Signature of Employee: _____ Date: _____

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.

PART B: SUPERVISOR ACKNOWLEDGEMENT OF INJURY OR ILLNESS

13. Part A of this form was completed by: (check one) Employee Designee Phone No. (_____) _____
If designee, full name of the designee: _____
14. First full shift the employee was unable to work due to injury or illness (if no time lost, enter "NLT"): _____
15. Was the employee able to return to work since missing a full shift? Yes No Did not lose full shift
If yes, check one of the following: Full Duty Temporary Alternate/Modified Duty
16. Has the employee been placed in a leave status? (check one) Yes No
If yes, type of leave: _____ Effective date: _____
17. Did employee die? Yes No
18. Full Name of Supervisor: _____
Date the employee reported the injury or illness to you: _____
19. Employee's choice of sick leave election (C-80, Part A) (check one) 1 2
Employee's choice of other time election (C-80, Part B) (check one) 1 2 3
Sick leave balance on date of injury or illness: _____
Vacation balance on date of injury or illness: _____ Amount of vacation time elected to be used: _____
20. If this report is not being submitted within one workday of the occurrence of the injury or illness, check the appropriate box and complete required information:
- Medical expenses incurred on: _____
 First full shift missed on: _____
 Other: _____

The above injury or illness was reported to me as indicated above. **I acknowledge receipt and understanding of the Supervisor's Guidelines.** I acknowledge the above information to be true and accurate to the best of my knowledge.

Signature of Supervisor: _____ Date: _____

Distribution:

ORIGINAL - Unit or Department Medical File
COPY - Workers' Compensation Program Area, Human Resources Division
COPY - State Office of Risk Management (SORM)
COPY - Risk Management Coordinator
COPY - Employee

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee's Election Regarding Use of Sick and Vacation Leave
C-80 (Part A)
(Texas Labor Code § 501.044)

Employee's Name: _____ Date of Injury or Illness: _____
MM/DD/YYYY
Employee's SSN: _____

Hours of Sick Leave Available as of Date of Injury or Illness: _____ Hours of Vacation Leave Available as of Date of Injury or Illness: _____

Complete Election 1 or Election 2.

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 vacation leave.
- B.** A portion of my accrued vacation leave (enter number of hours: _____).
- C.** None of my accrued vacation leave.

Sick leave shall be exhausted before vacation leave can be used.

I understand I cannot receive workers' compensation payments while using sick leave, sick leave pool, extended sick leave, vacation leave, or donated sick leave.

ELECTION 2

- When I lose time from work due to this injury or illness, I elect to **not** use any accrued sick leave and not use any accrued vacation leave. I understand I shall not receive workers' compensation payments until after the waiting period of seven calendar days.

MONTHLY TEMPORARY INCOME BENEFITS ELECTION

- I elect to change my Temporary Income Benefits frequency from weekly to monthly.

I have read the Employee's Guidelines and understand the effect this election may have on my paycheck and benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness. 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 instructions on page 2.

(Employee's Signature/Date)

(Supervisor's or Human Resources Representative's Signature/Date)

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.

Distribution:

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

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

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 vacation leave for time missed from work due to the work-related injury. Accrued sick leave and accrued vacation 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 vacation leave.

All sick leave must be exhausted before vacation 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 vacation leave before receiving workers' compensation income benefits.

If you select 1B, you must use any sick leave balance and any authorized vacation 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 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 if 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.

If You Choose Election 2

You choose to not use any sick or vacation leave for your compensable injury. You may immediately be placed in a leave without pay (LWOP) 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 eighth 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 to 75% of your weekly wage depending on your wages at the time of your injury.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee's Other Time Election
C-80 (Part B)

Choose one of the following elections by initialing in the space beside it:

_____ **ELECTION 1**

When I lose time from work due to this injury or illness, I hereby elect to use all my accrued compensatory, holiday, and overtime UNTIL THE BALANCES ARE EXHAUSTED or I return to work, whichever occurs first.

_____ **ELECTION 2**

When I lose time from work due to this injury or illness, I hereby elect TO NOT USE ANY accrued compensatory, holiday, and overtime, thereby freezing all balances until I return to work. I understand I may not receive workers' compensation benefits until after the waiting period of seven calendar days.

_____ **ELECTION 3**

When I lose time from work due to this injury or illness, I hereby elect to USE THE PORTION INDICATED below of my accrued compensatory, holiday, and overtime, thereby freezing the remaining balance until I return to work. I have indicated the total amount of time in each category to use:

- | | | |
|----------------------|-------|---------------|
| A. COMPENSATORY TIME | _____ | HOURS/MINUTES |
| B. HOLIDAY TIME | _____ | HOURS/MINUTES |
| C. OVERTIME | _____ | HOURS/MINUTES |

EMPLOYEE'S NAME AS SHOWN ON PAYROLL (PRINT OR TYPE)

EMPLOYEE'S SSN

DATE OF INJURY OR ILLNESS (mm/dd/yyyy)

I understand:

I cannot receive workers' compensation payments while using accrued sick leave, sick leave pool, donated sick leave, or while on extended sick leave and vacation leave.

I shall request LWOP - Medical before my accrued leave is exhausted.

That holiday time shall be used within one year from the end of the work cycle in which the time was accrued; and compensatory time shall be used within one year from the end of the work cycle in which the time was accrued (two years for correctional staff only). If I freeze this time and it expires before I return to work, it cannot be restored.

I may not change Part B once the DWC FORM-1S, Employer's First Report of Injury or Illness has been submitted to the State Office of Risk Management until after returning to work for one full shift. Subsequent changes to Part B shall not be retroactive.

I have read the Employee's Guidelines and understand the effect this election may have on my benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness.

EMPLOYEE'S SIGNATURE

DATE

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.

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Authorization for Release of Information
(SORM-16)

Patient _____
Last Name First Name MI

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management, and 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 drug tests, x-rays, x-ray reports, including copies thereof, pertaining to the physical and mental condition which is the basis of my workers' compensation claim. This includes not only all current and 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 shall be considered valid as the original.

This is not a release of claims for damages.

DATED: _____ SIGNED: _____
(mm/dd/yyyy)

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

Form No. SORM-16 9-98

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

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee's Acknowledgement of Responsibilities
Relating to Work-Related Injury or Illness

I hereby acknowledge that I have read, understood, and received the following advisement.

Assistance	The TDI-DWC provides an ombudsman to assist me at no cost. The ombudsman may be reached by calling 1-800-252-7031 or the local office of the TDI-DWC.
Length of Time Benefits are Available	I recognize that benefits continue only until I have reached maximum medical improvement or until 104 weeks have elapsed from the beginning date of workers' compensation disability, at which time other benefits may be available.
Offer of Outside Employment	I shall notify my TDCJ human resources representative and the State Office of Risk Management of any bona fide offer and acceptance of employment.
Employment Status	If I am receiving workers' compensation benefits, I shall notify my TDCJ human resources representative and the State Office of Risk Management within one workday of getting another job.
Receipt of Wages	I shall report any wages received after the date of injury or illness while benefits are continuing to my TDCJ human resources representative and the State Office of Risk Management.
Warning Against Misrepresentation	I understand that any misrepresentation or concealment of information concerning my claim may be a violation of federal or state law.

Employee:

Human Resources Representative:

(Print) Last Name First Name MI

(Print) Last Name First Name MI

Title

Title

(Area Code) (Telephone #)

(Area Code) (Telephone #)

Time of Advisement Date Place

Employee Signature Date

HR Representative Signature Date

Distribution:
ORIGINAL - Unit or Department Medical File
COPY - Employee

**TEXAS DEPARTMENT OF CRIMINAL JUSTICE
DWC FORM-48, “Request for Travel Reimbursement”**

The TDI-DWC Rule § 134.110 provides that an injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when: (1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives; and (2) the distance traveled to secure medical treatment is greater than 30 miles, one-way.

Employees requesting reimbursement for travel expenses shall use the DWC FORM-48, “Request for Travel Reimbursement/Solicitud De Reembolso” form.

Employees may request their human resources representative provide them with a copy of the form or print the DWC FORM-48 from the following TDI-DWC website:

<http://tdi.texas.gov/forms/dwc/dwc048trvlreim.pdf>



THE STATE OFFICE OF RISK MANAGEMENT WORKERS' COMPENSATION PRESCRIPTION INFORMATION

Employer:

Please complete the employee information below and provide the employee with this document to take with their prescriptions to any pharmacy.

Employee Name:	
Group#:	10602772
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211

Day supply is limited to 30 days for a new injury
myMatrixx Help Desk: (877) 804-4900

Employee:

The State Office of Risk Management has partnered with *myMatrixx* to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee, if not already filled in by employer, to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

CareWorks Managed Care Services
10535 Boyer Blvd., Ste 100
Austin, TX 78758

P: 800.580.1314
F: 800.580.3123
E: Compkey@careworksmcs.com



Workers' Compensation Network Acknowledgement

I have received information that tells me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network.
2. I may ask my HMO primary care physician to agree to serve as my treating doctor.
3. 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 anywhere.
4. The insurance carrier will pay the treating doctor and other network providers.
5. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

_____ Signature	_____ Date		
_____ Printed name	_____ SSN	_____ Unit/Dept	
_____ Street Address			
_____ City	_____ State	_____ Zip code	_____ County
_____ Name of employer			
CAREWORKS HCN			
_____ Name of network			

CareWorks



Employee Notice of Network Requirements

Important Medical Care Information for Work-Related Injuries and Illnesses

An employer that subscribes to workers' compensation must pay for medical care if you are injured at work. Your employer provides this medical care by using a certified workers' compensation health care network called CareWorks CompKey Plus HCN. This notice explains what you need to know about the CareWorks CompKey Plus HCN including how to get care if you are injured on the job. If you are injured, you will receive this information again along with a current list of providers.

If you have questions, please contact CareWorks HCN by mail, phone, fax, or email. The toll free number is available 24 hours a day. You can call the Network during regular work hours. The Network Assistant will be your contact person for questions or assistance.

CareWorks CompKey Plus HCN
10535 Boyer Blvd., Ste 100 Austin, TX 78758

p: 800.580.1314

f: 800.580.3123

e: compkey@careworksmcs.com

The following questions and answers should help you understand the Network program.

- 1. What is a certified workers' compensation health care network?** It is a program certified by the state of Texas. Your employer uses the CareWorks HCN to provide medical care for work injuries. The medical providers in the Network have agreed to provide quality care according to network treatment and return-to-work guidelines. These providers have agreed to bill the insurance carrier or your employer. The provider should not ask you for payment.
- 2. Do I have to receive all of my medical care for my work injury from the Network no matter where I live?** Yes, if you live within a "service area" of the Network. If a specialist is needed but not available in your area, your treating doctor will contact the Network for approval for treatment outside of the Network. Appointments with Network specialists must be arranged on a timely basis within the time appropriate to the circumstances and conditions of the injured employee, but not later than 21 days after the date of the request.
- 3. What is a service area?** A service area is a geographical area. Where you live depends on what service area applies. A service area must have enough different types of medical providers in that region. Enclosed with this notice is a map showing the service area(s) by county.
- 4. How do I know if I live in a service area or not?** The Network can help you. You have to receive care from a network provider if you live within a service area. Treating doctors and hospitals should be available within 30 miles if you live in a non-rural area. If you live in a rural area, the treating doctor and hospital must be within 60 miles. A specialist or specialty hospital should be available within 75 miles.
- 5. What if I do not live in a network service area?** Contact your insurance carrier and explain that you do not live in a service area. If the carrier disagrees, you can ask for a review. You can send any information to support your claim. The carrier must make a decision in 7 days and provide the decision in writing. The carrier must tell you the reasons for the decision. If you disagree, you may file a complaint with the Texas Department of Insurance. Instructions for filing a complaint are included in the decision. If you choose to use an out-of-network provider while waiting for the decision, you may have to pay for the medical services received. You might want to use a network provider while you are waiting for a decision. By using the network provider, you will not be responsible for payment if it is decided that you do live in a network service area.
- 6. Do I have to pay for my medical care if I don't receive care from a network provider?**
Possibly.

If you live in a service area, your care should come from network providers unless it is an emergency. There may be times when a certain type of specialist is not available in your service area. Your treating doctor must get approval from the network before sending you to an out-of-network provider. So, if your care is provided by network doctors or you have approval for out-of-network care, you will not be

billed. If it is an emergency, you will not be billed. But, if you decide to get treatment from an out-of-network provider without getting approval from the CareWorks HCN, except in emergencies, you may have to pay for the services.

7. **Does the certified workers' compensation health care network cover the entire state?**

Although some networks may cover the entire state, many do not. Some of the rural areas don't have enough providers. For those areas that do not have enough providers, an out-of-network provider may be approved.

8. **How do I find medical care if I am hurt at work?** If you have a medical emergency or need care after normal work hours, please refer to questions 12 and 13. As soon as possible, tell your employer that you have had an injury at work. If you do not have an emergency, you need to pick a treating doctor in the network. The employer or insurance carrier will give you a list of all of the treating doctors in your service area. You must pick a doctor off of the list.

You can also obtain a listing of medical providers at www.careworks.com. Select "Managed Care for TPAs" Select "Find a Provider" Select "CompKey Plus TX HCN". Select to search by Specialty, Address, County, or State.

9. **How do I pick a treating doctor?** Except for emergency care, your treating doctor will provide all of your care. The treating doctor will make referrals to specialists as needed. You may pick a treating doctor from the list of network doctors where you live. This list will be given to you by your employer or insurance carrier at the time of injury. A current list of network providers in your service area is enclosed. This list is updated quarterly.

If you need help finding a treating doctor, you may contact the CareWorks HCN at 800.580.1314 and state that you are a member of the CareWorks HCN. The network will assist with helping you pick a treating doctor and/or providing you a list of providers within your service area.

You may also use your HMO primary care doctor for your work injury. Your HMO doctor must agree to follow the network guidelines. If you decide you want to change your treating doctor, you must pick a doctor that is in the network.

If you become dissatisfied with an alternate treating doctor you must obtain authorization from the network to select any subsequent treating doctor. You may contact the network to begin this process.

10. **What if I need to get other health care services or see a specialist?** Except for emergencies, your treating doctor will provide all of your care. If needed, the treating doctor will send you for other services. The treating doctor may also send you to a specialist. Specialist referrals must be arranged on a timely basis within the time appropriate to the circumstances and conditions of the injured employee, but not later than 21 days after the date of the request.

11. **What if there are no doctors in my area?** Please see the answer to question 5. There may be times when you can get approval for care with an out-of-network doctor. The reasons out-of-network care may be approved include: an employee who needs a different medical service or specialist not currently available to the employee, or if the employee decides to temporarily live outside the network service area. If you have questions regarding provider availability in your area, contact your adjuster or contact the CareWorks HCN at 800.580.1314.
12. **How do I obtain emergency care?** If you have a medical emergency, you should call 911 or go to the closest emergency room or urgent care center, which may be a non-contracted provider/facility.
13. **How do I obtain after hours care?** If it is not an emergency, but you need after hours care, you can obtain a listing of hospitals and urgent care centers at www.careworks.com. If you do not have an emergency, but simply need care after normal work hours and you go to the nearest emergency room or urgent care center, which may be a non-contracted provider/facility, then you may be responsible for payment of services received.
14. **What medical treatment or services must be pre- approved?** The following treatment and services must be approved before the care is provided.
- All surgeries
 - All inpatient admissions to any facility
 - All psychological/psychiatric services after the initial evaluation
 - All physical and occupational therapy after the first six visits
 - All physical and occupational therapy after the first six visits of therapy following the evaluation when such treatment is rendered within the two weeks immediately following:
 - the date of injury, or
 - a surgical intervention previously pre-authorized by the carrier
 - All work hardening/conditioning regardless of CARF status
 - All chiropractic manipulations after two weeks of services
 - All chronic pain management programs
 - All services outside the ODG-TWC and/or ACOEM treatment guidelines unless a treatment plan was previously approved
 - All stimulators, including TENS, for rental or purchase
 - Any treatment for an injury or diagnosis that is not accepted by the carrier as a result of a treating doctor examination to define the compensable injury(ies)
 - Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:
 - drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

- any compound that contains a drug identified with a status of “N” in the current edition of ODG Treatment in Workers’ Comp (ODG) / Appendix A, ODG Workers’ Compensation Drug Formulary, and any updates; and
- any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care

15. **What happens if the services above are not pre- approved?** You and your doctor will receive a letter telling you why it was denied. The letter will give you specific instructions on how to file a reconsideration. You, a person acting on your behalf, or your doctor may file a request for reconsideration. A reconsideration request must be made within 30 days of the denial. To request a reconsideration, you, the person acting on your behalf, or your doctor can contact CareWorks HCN.

CareWorks CompKey Plus HCN
10535 Boyer Blvd., Ste 100
Austin, TX 78758

p: 800.580.1314

f: 800.580.3123

e: compkey@careworksmcs.com

attn: Reconsiderations

A different doctor will review the reconsideration than did the first review. The network will send the requestor a letter confirming the date the reconsideration request was received. The letter will be sent within 5 calendar days of receiving the request. It will include a list of the documents that must be submitted to complete the review.

The review will be completed within 30 days of the request. The network will send you or a person acting on your behalf, and your doctor a letter telling you the outcome of the review. It will list the specific medical reasons and basis for the decision. Any provider who was contacted during the review, their specialty and the state where they are licensed will be given.

You have the right to an expedited reconsideration of an adverse determination for post-stabilization, continued in- patient hospital stays, or a life-threatening condition. The expedited review shall be completed and the requestor notified within 1 calendar day of the decision. You are entitled to an immediate review of an adverse determination if you have a life-threatening condition. In this case, you are not required to comply with the procedures for a reconsideration. You may request an independent review organization review directly.

You have the right to request an independent review of a reconsideration determination by an independent review organization. A request for an independent review must be made within 45 days of the reconsideration being denied. You may get an independent review form from the Texas Department of Insurance website at www.tdi.state.tx.us. You may also mail a request to the Managed Care Quality Assurance Office, MC 111-1A, Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104.

16. **What happens if my doctor leaves the Network?** The Network has a “Continuity of Care” plan to make sure you receive the necessary care if your provider leaves the network. There are two main reasons for providers leaving.

- At the doctor’s request.
- At the network’s request because of quality concerns or criminal activity that could cause harm to you.

If your doctor is terminated, you will be contacted to discuss your options. If a condition exists in which changing doctors could harm you, the network will let you continue treatment with the terminated doctor for 90 days. The Network will assist you in this process.

17. **If I am not satisfied with the Network or a Network decision, how do I file a complaint?** If you have a complaint about any network services or providers, you can file a complaint by calling, writing, or emailing the CareWorks HCN. The network cannot retaliate against you, your employer, doctor, or any person filing for you regarding a complaint or appeal a decision of the network.

To file a complaint, you must contact the CareWorks HCN within 90 days after the event.

CareWorks CompKey Plus HCN
10535 Boyer Blvd., Ste 100
Austin, TX 78758

p: 800.580.1314

f: 800.580.3123

e: compkey@careworksmcs.com

When a complaint is received, you will be sent an acknowledgement letter within 7 days. The letter will describe the complaint procedures and deadlines. The CareWorks HCN will review and resolve the complaint within 30 days of receipt. You will receive a letter explaining the outcome.

If you disagree with the network’s resolution of your complaint, you may file a complaint with the Texas Department of Insurance (TDI). You can obtain a copy of the complaint form at www.tdi.state.tx.us. You

can also request the form from the TDI at Managed Care Quality Assurance Office, MC 111-1A, Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104.

The Texas legislature has made workers' compensation health care networks available to you and your employer. These networks should increase the quality of care provided to injured workers. This will help injured workers recover and return to work as soon as medically approved. If you have any questions, complaints' or suggestions about this program, please contact the CareWorks HCN at 800.580.1314.

**TEXAS DEPARTMENT OF CRIMINAL JUSTICE
DWC FORM-73 Notification**

Beginning May 1, 2006, health care providers shall use the DWC FORM-73, "Texas Workers' Compensation Work Status Report," which replaced the TWCC FORM-73, "Texas Workers' Compensation Work Status Report."

The new form may be obtained from the following TDI-DWC Texas Department of Insurance, Division of Workers' Compensation forms webpage:

<http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf>

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

CONTENTS

PERS 299-1, Supervisor's Guidelines for Workers' Compensation

PERS 299-2, Witness Statement

PERS 299-3, Supplemental Worksheet

TEXAS DEPARTMENT OF CRIMINAL JUSTICE Supervisor's Guidelines for Workers' Compensation

Do not delay emergency medical treatment pending completion of packet!

- ◆ **Maintain an ample supply of Employee and Supervisor 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.**

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Witness Statement
(Please print or type)

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

ALL WITNESSES - COMPLETE THE FOLLOWING	
On _____ <small>Date (mm/dd/yyyy)</small>	at about _____ <small>Time</small> (Circle One) AM or PM I was (clearly state your exact location at the time of the alleged accident) _____
When an accident involving the above employee is alleged to have occurred. CHECK APPLICABLE BOX:	
<input type="checkbox"/> I observed the accident and it occurred in the following manner: _____	
Other pertinent information and source: _____	
<input type="checkbox"/> I did not observe the accident; however, information given to me by (injured or ill employee or witness) indicates it occurred as follows: _____	
Other pertinent information and source: _____	
<input type="checkbox"/> 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 (SORM)
COPY - Employee

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

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
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

TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Return to Work Program Pooled Areas

01. PANHANDLE

Amarillo
Pampa
Dalhart
Tulia
Childress
Plainview

02. LUBBOCK AREA

Brownfield
Lamesa
Colorado City
Snyder
Lubbock

03. WEST TEXAS

Ft. Stockton
El Paso
Monahans*
Midland/Odessa*
Del Rio*
San Angelo*

04. NORTH TEXAS

Wichita Falls
Dallas
Denton*
Mineral Wells*
Fort Worth*
Sherman*
Waxahachie*
Greenville*
Garland*

05. NORTHEAST TEXAS

Bonham
New Boston
Winnsboro
Texarkana*
Paris*
Mount Pleasant*
Marshall*
Longview*

06. ABILENE AREA

Abilene
Breckenridge
Big Spring*

07. PALESTINE AREA

Palestine
Teague
Rusk
Tyler*
Athens*

08. CENTRAL TEXAS

Brownwood
Gatesville
Marlin
Burnet
Austin
Waco*
Temple*
Georgetown*
San Saba

09. HUNTSVILLE AREA

Lovelady
Midway
Livingston
Huntsville
Conroe*

10. DEEP EAST TEXAS

Jasper
Woodville
Diboll
Nacogdoches*

11. NAVASOTA AREA

Navasota
Bryan

12. SOUTHEAST TEXAS

Beaumont
Liberty
Galveston
Dayton
Nederland*
Orange*
Port Arthur*
Texas City

13. HOUSTON AREA

Richmond
Rosharon
Angleton
Humble
Rosenberg*
Houston*

14. BEEVILLE AREA

Cuero
Kenedy
Beeville
Victoria*

15. SAN ANTONIO AREA

Hondo
Dilley
Cotulla
San Antonio
Seguin*

16. SOUTH TEXAS

San Diego
Edinburg
Laredo*
McAllen*
Harlingen*
Corpus Christi*

*Parole Offices Only

TEXAS DEPARTMENT OF CRIMINAL JUSTICE Offer of Temporary Alternate or Modified Duty Assignment

EMPLOYEE INFORMATION	
Name:	SSN:
Mailing Address:	Date of Injury or Illness: <small>(MM/DD/YYYY)</small>
City, State, and Zip Code:	

The Texas Department of Criminal Justice is in receipt of your Authorization to Release Medical Information and Return to Work Status Form indicating you have been released to perform a temporary alternate or modified duty assignment. The TDCJ is offering you a temporary alternate or modified duty assignment as described on the second page. This assignment shall abide by the temporary physical or mental limitations set out on the **attached** DWC FORM-73, Texas Workers' Compensation Work Status Report, or health care provider's statement. **Human resources representatives shall attach one of these documents.**

- Indicate whether you accept or reject the temporary alternate or modified duty assignment on the second page of this form and return both pages of this form to the human resources representative within three workdays of receipt of this form.
- If you choose to reject the temporary alternate or modified duty assignment: (1) indicate your rejection on the second page of this form; and (2) within three workdays of receipt of this form, return both pages of this form to the human resources representative.
- Failure to respond to this offer within the specified time frame shall be considered an official rejection. The State Office of Risk Management may reduce your future workers' compensation benefits.

If you have any questions regarding the temporary alternate or modified duty assignment, job modifications, accommodations, leave entitlements, benefits, etc., contact your human resources representative.

HUMAN RESOURCES REPRESENTATIVE: _____ **Unit or Department:** _____

Printed Name: _____ **Telephone No.:** (____) _____

Signature: _____ **Date:** _____

FOR STATE AGENCY USE ONLY	
Initial verbal offer made <input type="checkbox"/> by phone <input type="checkbox"/> in person on _____ . Verbal offer was <input type="checkbox"/> accepted <input type="checkbox"/> rejected (check one). <small>(MM/DD/YYYY)</small>	
Offer sent to employee via certified mail on _____ Certified Mail Receipt No.: _____ <small>(MM/DD/YYYY)</small>	
Temporary alternate or modified duty assignment begins: _____ <small>(MM/DD/YYYY)</small>	
Projected expiration date (end of maximum 12 consecutive work week period): _____ <small>(MM/DD/YYYY)</small>	
Employee acknowledgement of temporary alternate or modified duty assignment period: _____ <small>Employee Signature</small>	_____ <small>Date (MM/DD/YYYY)</small>
Temporary alternate or modified duty assignment expired: _____ <small>(MM/DD/YYYY)</small>	
Reason assignment expired: <input type="checkbox"/> End of Maximum 12 Consecutive Work Week Period <input type="checkbox"/> Other: _____	
Employee acknowledgement of expiration of assignment: _____ <small>Employee Signature</small>	_____ <small>Date (MM/DD/YYYY)</small>

Temporary Alternate or Modified Duty Assignment Description

EMPLOYEE INFORMATION		
Name:	SSN:	Date of Injury or Illness: <small>(MM/DD/YYYY)</small>
A. Location	B. Schedule	
Unit or Department:	Work Schedule:	Card Schedule:
Address:	Work Hours: to	Hours Per Week:
	Assignment to Begin:	
Approximate Miles from Employee's Residence:	Projected Expiration Date:	
C. Wages		
\$ Monthly	Your rate of pay shall be the same as your current pay rate.	

D. Duties or Tasks: You shall only be assigned tasks consistent with your physical abilities, knowledge, and skills. Training shall be provided, if necessary.

E. Maximum Physical Requirements: The following identifies the maximum physical requirements for this assignment.

Maximum Hours per day:	0	2	4	6	8	Other	Maximum Hours per day:	0	2	4	6	8	Other
Heavy lifting, 45 lbs & over	<input type="checkbox"/>	_____	Sitting	<input type="checkbox"/>	_____								
Moderate lifting, 15-44 lbs	<input type="checkbox"/>	_____	Crawling	<input type="checkbox"/>	_____								
Light lifting, under 15 lbs	<input type="checkbox"/>	_____	Twisting	<input type="checkbox"/>	_____								
Heavy carrying, 45 lbs & over	<input type="checkbox"/>	_____	Kneeling	<input type="checkbox"/>	_____								
Moderate carrying, 15-44 lbs	<input type="checkbox"/>	_____	Pushing	<input type="checkbox"/>	_____								
Light carrying, under 15 lbs	<input type="checkbox"/>	_____	Stooping	<input type="checkbox"/>	_____								
Straight pulling	<input type="checkbox"/>	_____	Climbing stairs	<input type="checkbox"/>	_____								
Pulling hand over hand	<input type="checkbox"/>	_____	Climbing ladders	<input type="checkbox"/>	_____								
Repeated bending	<input type="checkbox"/>	_____	Use of firearm	<input type="checkbox"/>	_____								
Reaching above shoulder	<input type="checkbox"/>	_____	Oper. motor equipment	<input type="checkbox"/>	_____								
Simple grasping	<input type="checkbox"/>	_____	Oper. motor vehicle	<input type="checkbox"/>	_____								
Dual simultaneous grasping	<input type="checkbox"/>	_____	Other (Explain below)	<input type="checkbox"/>	_____								
Walking	<input type="checkbox"/>	_____							_____				
Standing	<input type="checkbox"/>	_____							_____				

- I am voluntarily **accepting** the temporary alternate or modified duty assignment offered through the Return to Work Program as described above *for a maximum period of 12 consecutive work weeks*. I fully understand the effect of accepting this assignment.
- I am **rejecting** the temporary duty assignment offered through the Return to Work Program as described above. I understand that as a result of rejecting the assignment, the SORM may reduce my future workers' compensation benefits.
- Reason for offer rejection: _____

Employee's Signature _____
Date (MM/DD/YYYY)

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.

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