

Send the specified copies to your
Workers' Compensation Insurance Carrier
 and the injured employee.
***Employers - Do not send this form to the
 Texas Workers' Compensation Commission,
 unless the Commission specifically requests a direct
 filing.**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number	4. Home Phone ()	5. Date of Birth (m-d-y)	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box			
City	State	Zip Code	County
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O.Box)			
City	State	Zip Code	

15. Date of Injury (m-d-y)	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y)	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where injury or Exposure Occurred Name of business if incident occurred on a business site			
Street or P.O. Box		County	
City	State	Zip Code	
24. Cause of Injury(fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y)	27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name	29. Date Reported (m-d-y)

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street	
City	State	Zip Code	City State Zip Code

44. Federal Tax Identification Number	45. Primary Standard Industrial Classification (SIC) Code* (4 digit)	46. Specific SIC Code* (4 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
 YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
 X _____ Date _____



DRIPPING SPRINGS INDEPENDENT SCHOOL DISTRICT

Human Resources Office

510 W. Mercer Street, P.O. Box 479, Dripping Springs, TX 78620-0479
Telephone: (512) 858-3009 Fax: (512) 858-3098

Workers' Compensation Leave Statement

Name _____ Social Security # _____

Position _____ Department/Campus _____

This employee is absent from duty because of a job-related illness or injury beginning on _____. If eligible, worker's compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

A handwritten signature in black ink, appearing to read "T. J. [unclear]", is written over a horizontal line.

District authorized signature

Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I choose the following option:

I choose to use all available paid leave. I understand that I will not receive workers' compensation weekly income benefits until I have exhausted all of my paid leave or to the extent that paid leave does not equal my pre-illness or -injury wage.

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

Employee signature

Date



DRIPPING SPRINGS INDEPENDENT SCHOOL DISTRICT

Human Resources Office

510 W. Mercer Street, P.O. Box 479, Dripping Springs, TX 78620-0479

(512) 858-3007, Fax (512) 858-3098

Ron Hill, Human Resources Director (ron.hill@dripping-springs.txed.net)

Amy Rossing, Human Resource Officer (amy.rossing@dripping-springs.txed.net)

Margie Simmons, Substitute Procurement (margie.simmons@dripping-springs.txed.net)

Norma Arnold, Admin. Assistant (norma.arnold@dripping-springs.txed.net)

WORKERS' COMPENSATION VERIFICATION OF COVERAGE

(Employee) _____ has reported a work-related injury/illness that occurred on _____. This injury may be covered under Workers' Compensation benefits. Dripping Springs ISD maintains coverage with the Texas Association of School Boards Risk Management Fund (TASB).

Please contact TASB at the phone number below to verify reasonable and necessary medical treatment. To file expenses incurred for this claim, please submit all bills to:

Texas Association of School Boards Risk Management Fund

P.O. Box 2010

Austin, Texas 78768

800-482-7276

512-467-9512 (Fax)

This notice is verification that Workers' Compensation coverage exists. It does not guarantee compensability of the reported injury. If you have any questions regarding this injury, please contact Dripping Springs ISD at 512-858-3009.

A handwritten signature in black ink, appearing to read "Ron Hill", is written over a horizontal line.

Ron Hill
Human Resources Director

Confidentiality Notice

This message and any attachments is intended for the sole use of the individual and entity to whom it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, or not authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute to anyone the message or any information contained in the message. If you have received this message in error, please immediately advise the sender by reply mail and delete this message. Thank you.



The Texas Association of School Boards and Progressive Medical, Inc. have joined together to provide injured parties with a "First Fill®" medication card program.

At the bottom of this form is a First Fill® medication card that enables injured parties to obtain the "initial" prescription(s) needed upon injury with little to no out-of-pocket expense. A sample list of "Participating Pharmacy Chains" that accept this medication card is included on the back of this card.

Instructions for Company to use this First Fill® Card:

- Injury occurs and a report of injury is made to the appropriate personnel.
- Fill in the ID/Auth# as instructed on the First Fill® card below along with the injured party's name, date of birth and gender.
- After explaining the instructions for this card, please give the injured party this document.
- Instruct the injured party to take the First Fill® card and their prescription to the pharmacy.
- Report the claim to the appropriate insurance company/TPA.
- The pharmacist fills the prescription; the bill is processed and sent to Progressive Medical.
- The First Fill® card is available for a one time use.

Please note: If additional, ongoing medication is required, the claims professional should contact Progressive Medical to utilize our Retail Drug Card program. If additional First Fill® cards are needed, or if you have any questions regarding the use of this program, please contact Progressive Medical at 1-888-908-MEDS and ask for the First Fill® Coordinator.

Instructions for the Injured Party to use this First Fill® Card:

- At the bottom of this form is a First Fill® card that will enable you to obtain the "initial" prescription(s) needed upon injury with little to no out-of-pocket expense. A list of "Participating Pharmacy Chains" that accept this First Fill® card is included on the back of this card.
- This card is for a one time use to receive your medication(s) per your employer/insurance company.
- Use of this card is restricted to your allowed condition.
- To receive this benefit, present this card to a participating pharmacy.
- If you have any questions, call Progressive Medical toll-free at 1-888-908-MEDS. Our Client Services Specialists are available 24-hours a day to take care of your needs.

Please note: If your claim is accepted, you will receive a Retail Drug Card in the mail. Present that card when filling subsequent related prescriptions. Please give Spanish speaking injured parties a copy of the English card filled in and the Spanish instructions attached to this letter. They will need the English form to show to the pharmacy.

(Please explain the First Fill® process to the injured party and give them this document.)

FIRST FILL® CARD
BIN#: Restat 600471
Company Name: _____
Group/Plan#: E127
Person Code: 00 (zero, zero)
ID/Auth#: _____
SSN (9 digits, no dashes) Date (6 digits, no dashes)
E.g. if the SSN is 000-00-0000 and today's date is May 21, 2007, the ID/Auth# is 0000000000052107.
Injured Party's Name: _____
Date of Birth: _____ Gender: _____

1-888-908-MEDS **PROGRESSIVE Medical, Inc.**
For claim submission issues, prior authorization or claim rejections, please contact Progressive Medical, Inc. at 1-888-908-6337.
Pharmacist: If you experience any problems, please call 1-888-908-6337.
Disclaimer: It is important to note the issue will be determined by the claims department and the confirmation of this treatment/service request is in no way intended as an endorsement of the treatment/service request, nor is it intended to interfere with the provider from his or her duty to adhere to any applicable practice standards. Paid Without Prejudice for CT, MA, and RI



Participating Pharmacy Chains

A W G Network	H E B Pharmacy	Raleys Drug Center
AccessHealth	Haggen Foods Pharmacy	Randalls Food & Drug, Inc.
Albertsons, Inc.	Hannaford Brothers	Revco Discount Drug/DBA CVS Pharmacy
American Drug Stores, Inc.	Harris Teeter Pharmacies	Rite Aid Corporation
Amerisource Bergen	Harvard Plus Pharmacy Network	Rx Pride, LLC
Arbor Drugs	Homeland Stores, Inc.	Safeway Pharmacy
Aurora Pharmacy, Inc.	Hy-Vee Pharmacy	Save Mart Pharmacy
Bartell Drugs	IHC Pharmacy Services	Sav-Mor Drug Stores
Bi-Lo Pharmacy, LLC	Ingles Markets, Inc.	Schnucks Pharmacy
Bi-Mart Drugs	K Mart Pharmacy	Shaws Supermarket, Inc.
BJ's Wholesale Club, Inc.	Kash n Karry Food Stores, Inc.	Shopko Pharmacy
Brooks Maxi Drug, Inc.	Kerr Drug, Inc.	Shoppers Good & Pharmacy of Washington
Brookshire Brothers, Ltd.	Kinney Drugs	ShopRite Financial Services
Brookshire Grocery Company	Leader Drug Stores	Snyder Drug Stores
Brunos Food & Pharmacy	Longs Drug Store	Stop and Shop Pharmacy
Coborns Corp. Pharmacy	Major Value Pharmacy Network	Super D Drugs
Costco Pharmacies	Managed Pharmacy Care	SuperValu Pharmacies, Inc.
CVS Pharmacy	Marc's Pharmacy	Target Pharmacy
Discount Drug Mart	Marsh Drug Store-IN	The Pharmacy Cooperative
Dominicks Pharmacy	Mays Drug Store	Third Party Station
Drug Fair-Community Distributors	McKesson MPPN Network	Thrifty White
Duane Reade-NY	Medicap Pharmacies, Inc.	Tom Thumb Pharmacies
Eckerd Drug Company	Medicine Shoppe Internet	Tops Market, LLC
Epic Pharmacy Network	Meijer Pharmacy	Truecare Pharmacy
Family Care Network	Metro-Group (A&P)	United Drugs
Family Fare Pharmacy	Nash Finch Company	United Pharmacy-TX
FamilyMeds, Inc.	NCS Healthcare	United Pharmacist Network, Inc.
Farm Fresh	Neighborcare Pharmacy	Value Health Center Pharmacy
Food City-K-VA-T Food Stores, Inc.	Oncology Pharmacy Services	Vons Companies, Inc.
Food Lion, LLC	Pamida Pharmacy	Walgreens Drug Store
Freds Pharmacy-AR	Pathmark Stores	Wal-Mart Pharmacy
Giant Eagle Pharmacy	People's Pharmacy	Wegman Food Market Pharmacy
Giant of Maryland	Performance Plus Network	Weis Pharmacies, Inc.
Giant Pharmacy	PPOK/Rx Select Pharmacy Network	Winn Dixie Pharmacy
Golub Corporation	Publix Pharmacy	

**For additional providers in your area, call Progressive Medical's
Customer Service Department: 1-888-908-6337**

www.progressive-medical.com



Progressive Medical, Inc. están trabajando juntos para proveerle al trabajador accidentado con el programa de tarjeta de medicamento llamada First Fill®.

En la parte baja de este formulario se encuentra la tarjeta de medicamento que permitirá al trabajador obtener el medicamento inicial después del accidente, con poco ó sin ningún costo de su parte. Una lista de Cadenas farmaceuticas, que participan con este programa, ha sido incluida al reverso de esta tarjeta.

Instrucciones para la compañía sobre el uso de la tarjeta First Fill®

- Accidente ocurre y empleado reporta el accidente al personal apropiado
- Provea el nombre del empleado, número social, fecha de accidente y fecha de nacimiento.
- Después de explicarle el uso de la tarjeta al empleado, por favor de le este documento.
- Instruya al empleado que presente esta tarjeta junto con la prescripción a la farmacia. (Refiera la lista de farmacias proveida con la tarjeta)
- Reporte el accidente a la compañía de seguro apropiada.
- La farmacia procesara los medicamentos y el cobro será enviado a Progressive Medical.
- La tarjeta First Fill® unicamente puede ser usada una sola vez.

Por favor, de suma importancia:

Si medicamentos adicionales sean necesarios, la persona encargada del caso en la compañía de seguro tendrá que contactar Progressive Medical para utilizar el programa de venta al menor de medicamentos.

Si más tarjetas de First Fill® son necesarias o si tiene preguntas en relación del programa, por favor contacte Progressive Medical al 1-888-908-MEDS(6337) y pregunte por el coordinador de First Fill®.

Instrucciones para el empleado accidentado acerca del use de tarjeta First Fill®:

- Este formulario será utilizado una sola vez para cubrir medicamento(s) autorizados por su compañía de seguro.
- El uso de esta tarjeta es restringida unicamente para su compensación de trabajo.
- Para recibir los beneficios, presente esta tarjeta a una de las farmacias participantes (Una lista de farmacias a sido provista en la parte posterior de este formulario). Debajo de este formulario encontrará la tarjeta First Fill® que le permitirá obtener los primeros medicamentos necesario por su accidente de trabajo con un mínimo o sin ningun costo alguno de su parte.
- Si tiene alguna pregunta, llame a Progressive Medical al 1-888-908-MEDS (6337). Nuestros coordinadores están disponibles las 24 horas al día.