CLAIMS COORDINATOR HANDBOOK FOR TEXAS STATE AGENCIES

A publication of the
State Office of Risk Management

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Mission Statement

The State Office of Risk Management will provide active leadership to enable State of Texas agencies to protect their employees, the general public, and the state's physical and financial assets by reducing and controlling risk in the most efficient and cost-effective manner.

Statement of Philosophy

The State Office of Risk Management will act in accordance with the highest standards of ethics, fairness, accountability and humanity for both our customers and our employees. Customer service is a cornerstone of our mission.

Vision Statement

The State Office of Risk Management will be recognized as a national leader through determined advocacy and significant contributions to enterprise-level risk management, and an ongoing focus on collaboration and continuous enhancement of agency expertise.

Culture Statement

The State Office of Risk Management will promote and preserve a culture of accountability, belonging, inclusion, diversity, and equity in all aspects of our organization.

Overview of the Texas State Employees' Workers' Compensation System

What Is It?

Workers' compensation laws are based upon the theory that the burden of on-the-job injuries should be shifted from the worker to the employing business, and ultimately to the consuming public, as a cost of doing business. These laws protect and benefit the employee by providing speedy, simple, effective, and inexpensive relief, without regard to the fault of the employer, the employee, or third parties(Texas Labor Code §406.031a)). However, the Texas Workers' Compensation Act does not prohibit the recovery of exemplary damages by the surviving spouse or heirs of the body of a deceased employee whose death was caused by an intentional act or omission of the employer or by the employer's gross negligence.

Prior to the enactment of such laws, injured workers often were denied any compensation for work- related injuries. In those cases where they were granted relief by the courts, it was usually only after a lengthy and expensive process.

In 1913, the Legislature passed Texas' first workers' compensation law, but it did not apply to state employees. It was not until 1973 that a workers' compensation statute was passed that is applicable to most state employees (Texas Civil Statutes, Article 8309g, now re-codified as Chapter 501 of the Texas Labor Code). SORM's funding is addressed in Section § 412.012. This section states:

"FUNDING. The office shall be administered through money appropriated by the legislature and through:

1. interagency contracts for purchase of insurance coverage and the operation of the risk management program; and
2. the allocation program for the financing of state workers' compensation benefits."

Under these statutes, the state is essentially self-insuring with respect to an employee's compensable injury.

Workers' compensation claims of state employees are filed with and determined by the State Office of Risk Management, but income and medical benefit disputes are adjudicated by the Texas Department of Insurance, Division of Workers' Compensation (DWC). The SORM executive director acts in the capacity of insurer as an adversary before DWC and the courts and presents the legal defenses and positions of the state as its insurer. The SORM executive director is authorized to make rules and prescribe forms(Texas Labor Code §412.041).

Throughout this handbook SORM will state the number of days in which a particular form, process, or procedure needs to be completed. The days stated will be a statutory requirement of the Texas Workers' Compensation Act, SORM's Administrative Rule or may be a "best practice" for workers' compensation claim handling. The term "best practice" is to emphasize prompt reporting of a claim enables SORM to provide timely applicable benefits and attention to the injured worker.

Who Is Covered?

A state employee, as discussed above, who sustains an injury in the course and scope of employment is entitled to receive compensation under this system. In the case of a fatality, the deceased employee's legal beneficiaries are entitled to benefits. The term "injury" includes occupational diseases.

A state employee is a person who is in the service of the state, whether that person is elected, appointed, or hired by oral or written contract, or whose state employment related duties require that the person work in a political subdivision of the state, but who is paid from state funds. Certain peace officers, as identified in Chapter 501, are also considered state employees for purposes of workers' compensation.

However, the following people are not considered employees of the state for purposes of workers' compensation:

- Independent contractors;
- Volunteers, except during a Governor-declared State of Emergency;
- Members of the state military forces, except while engaged in authorized training or duty; (§ 501.001, (D).);
- Persons covered by federal workers' compensation;
- Offenders; and
- Consumers or patients of a state institution or agency.

The following groups have their own workers' compensation programs:

- Employees of the University of Texas System;
- Employees of the Texas A&M University System; and
- Employees of the Texas Department of Transportation.

In most cases it is easy to determine if an on-the-job injury has occurred, but some cases require further investigation. However, it is not the claims coordinator's responsibility to make this determination. If the injured employee feels that the injury or illness is work-related, then it should be reported. The determination of compensability is made by SORM, whose decisions may be disputed before DWC.

Claims investigation is discussed in more detail later in this handbook.

What Does It Pay For?

Weekly Compensation

Payment of compensation for time lost from work due to an on-the-job injury is made directly to the employee on a weekly basis unless monthly benefits are requested. Only those employees who are physically unable to perform their usual job tasks for more than seven days following the date of injury are eligible to receive weekly compensation payments. The first seven calendar days following the injury date are called the waiting period and no weekly compensation payment is due for the time lost for that period. However, if an employee is off work for more than 14 calendar days, the weekly compensation for the waiting period is paid retroactively. (Act, §408.082).

An injured employee may elect to use sick and/or annual leave instead of receiving lost-time benefits. While sick/annual leave is being used, lost-time benefits will not be paid. (Act, §501.044).

There are differences if the employee elects to receive lost-time benefits. The amount of each week's lost-time compensation payment is calculated as a percentage of the employee's average weekly wage, subject to a maximum and a minimum limit established by the Texas Workers' Compensation Act. The average weekly wage includes compensation for non-pecuniary benefits, such as the insurance premiums, lodging, personal use of state

vehicle, uniforms, and other wages paid to the employee in a form other than money. The injured employee is responsible for paying the insurance premium when the agency is no longer covering that fringe benefit.

Compensation Due in Fatal Cases

Beneficiaries of a deceased employee receive weekly compensation payments equal to a percentage of the employee's average weekly wages, subject to a maximum and a minimum amount established by the Texas Workers' Compensation Act. Weekly payments to a surviving spouse are payable for life or until the spouse remarries.

An eligible spouse is entitled to receive death benefits for the remainder of his or her life unless the spouse has remarried. If the spouse has remarried, he or she will be entitled to a lump sum equivalent to 104 weeks of death benefits. Texas Labor Code (TLC) Section 408.183(b). This lump sum amount is calculated by multiplying the amount of death benefits the spouse received the week prior to the remarriage by 104. Any benefits that the insurance carrier paid to the spouse after the remarriage will be deducted from the 104-week amount. 28 TAC Section 132.7(d).

NOTE: Notwithstanding TLC Section 408.183(b), above, an eligible spouse who remarries on or after September 1, 2017, is eligible for death benefits for life if the employee was a first responder, as defined under TLC Section 504.055, who died in the course and scope of employment or while providing services as a volunteer. TLC Section 408.183(b-1). This subsection applies regardless of the date on which the death of the first responder occurred.

In the event of remarriage, a lump-sum (commuted) payment equal in amount to the compensation due for a period of two years is paid. Weekly payments to a child shall continue until the age of 18 or beyond such age if the child is dependent (disabled at the time of the injury), or until 25 years of age if enrolled as a full-time student in an accredited educational institution. All other beneficiaries (where there is neither a surviving spouse nor child) are due weekly payments for 364 weeks(Texas Labor Code §408.183).

Medical Services Payment

Selection of Doctor

Non-Network claims: The employee is entitled to the employee's initial choice of doctor. If the employee is dissatisfied with the initial choice of doctor, the employee may notify DWC and request approval to treat with an alternate doctor. The notification should be on an Employee's Request to Change Treating Doctors (DWC-53) form.

Network claims: The employee is entitled to the employee's initial choice of doctor. The doctor must be within the SORM-contracted Workers' Compensation Health Care Network (CareWorks CompKey Plus Healthcare Network, "Careworks"). A list of physicians in the employee's area can be found on the SORM website.

If the employee is dissatisfied with the initial choice of doctor, the employee may contact CareWorks and request approval to treat with an alternate doctor. The employee is allowed one change of doctor, but it must be processed through CareWorks.

Medical Fees and Charges

Medical providers shall bill on the prescribed forms and according to the medical fee guidelines established by DWC. SORM will pay only for those services that are determined to be reasonable and necessary and related to the injury. By statute and rule, DWC has specified 14 treatments that require pre-authorization or prior approval. Without this approval, SORM may not be responsible for payment of the services rendered. Rule 134.600 of Title 28 of the Texas Administration Code has the list of services needing preauthorization.

Employees eligible for workers' compensation medical services should be instructed to inform the health care provider that the injury may be covered by workers' compensation provided by the State of Texas, and to give the health care provider their SORM claim number.

Artificial Appliances and Prosthetic Devices

SORM will pay for artificial appliances and prosthetic devices in cases where the injuries have necessitated their use. However, the breakage of eyeglasses or hearing aids, where there is no additional loss of visual capacity or hearing, is considered damage to property and does not meet the definition of "injury" within the law. Such property damage is not compensable.

Prescriptions

A Preferred Provider Program is also available to injured employees. When the employee charges a prescription, the pharmacy will submit a Statement for Pharmacy Services directly to SORM for payment. SORM will pay only for prescriptions that are reasonable and necessary and related to the injury. Employees may be reimbursed for initial prescriptions paid out of pocket by filing a SORM-81 (Medical Reimbursement Form) to SORM directly.

Contact Information

SORM Contact Information:

Main Phone Line:
(512) 475-1440 – Main
(512) 370-902 – Fax
(877) 445-0006 – Toll-free
(877) 445-0006 – SORM Fraud Hotline

SORM Mailing Address:
P.O. Box 13777
Austin, TX 78711-3777

SORM Physical Address:
300 W. 15th Street, 6th Floor
William P. Clements, Jr. Building
Austin, TX 78701

Phone numbers for preauthorization and pharmacy providers are available by calling SORM's main number.

Injured employees can contact SORM through the toll-free number.

Suspected fraud or abuse of the workers' compensation system can be reported to SORM's toll-free fraud hotline.

Information about SORM and claims forms can be accessed from SORM's website at www.sorm.texas.gov.

Send all correspondence to SORM to this address:

U.S. Mail:
State Office of Risk Management
P.O. Box 13777
Austin, TX 78711-3777

Interagency Mail:
State Office of Risk Management
300 W. 15th St., 6th Floor William P. Clements, Jr. Building Austin, TX 78701

Phone numbers for preauthorization and pharmacy providers:

CareWorks CompKey Plus HCN
10535 Boyer Blvd., Ste 100
Austin, TX 78758
Toll Free: (800) 580-1314
Fax: (800) 580-3123
Email: compkey@careworksmcs.com
Website: https://www.careworks.com

MyMatrixx
3111 W. Martin Luther King Jr. Blvd., Suite 800
Tampa, Florida 33607
Toll Free (877) 804-4900
Fax (813) 247-3391
Email: customerservice@mymatrixx.com
Website: https://www.mymatrixx.com

In the following pages, you will see reference to the Act – this is the Texas Workers' Compensation Act (Act) which is located within the Texas Labor Code.

The State Office of Risk Management (SORM) is providing these rules and references as a courtesy. While we make every effort to ensure the information is accurate and complete, the official version of applicable or adopted rules and references are filed with the Secretary of State and the Texas Department of Insurance, Division of Workers' Compensation. Click here to go to 28 TAC Part 4 and the Texas Labor Code, Title 5 - Workers' Compensation Act, (Act) and available from the Texas Department of Insurance, (TDI) website here.

Employer Responsibilities

All employing agencies are required to fully cooperate with SORM and TDI, Division of Workers' Compensation (DWC) in any way that may be required to properly administer the state employee's workers' compensation program.

State agencies are responsible for certain required "employer" reports and forms described in this handbook. Please see Chapters 408 and 409 of the Act for a description of the employer's responsibilities for reporting injuries and employer requirements for administering claims.

Send Timely Notices, Reports, and Information
An agency is required to give notices, make reports, and otherwise transmit information to SORM and to DWC concerning on-the-job injuries and occupational diseases/illnesses in a timely manner. Most of these notices and reports must be given or made within a certain time period after the event or occurrence. The sections appearing later in this handbook explain how and when to file specific forms.

Designate a Claims Coordinator
Each agency must designate one or more claims coordinators, as may be necessary, and must report to SORM any change in this designation. The role of the claim coordinator is discussed later in this handbook.

> RULE §251.213 Claims Coordinator
> Each employing agency will designate one or more claims coordinators, as may be necessary, who will be responsible for receiving notice of injury from fellow employees and for completion of all required reports and submission to the director. The employing agency will report to the director any change in personnel designated as claims coordinator.

Compliance with Rules
Agencies must comply with all rules enacted by SORM, as well as those of DWC. Agency policies, guidelines, or instructions must not vary from DWC rules, SORM rules, or with the Act. As the employer of record, state agencies are subject to administrative penalties for violations of the Act which may be assessed against the employer by the DWC Compliance and Practices Division (see Chapter 415 of the Act). DWC can assess monetary administrative penalties on the employer for failing to file certain documents on time, such as the first report of injury, the wage statement, or the supplemental report of injury. Instructions for filling out and filing these forms are included in this handbook. Please contact DWC's Information Services at 800-252-7031 Option 1 or your local DWC Field Office for information regarding employer requirements and administrative violations.

Keep Adequate Records

Each agency must make a record of all injuries sustained by employees in the course of employment. DWC Rule 120.1 states that agencies must maintain these records "until the expiration of five years from the last day of the year in which the injury occurred or the period of time required by Occupational Safety and Health Administration standards and regulations, whichever is greater." Occupational disease records may be required to be kept for 30 years beginning from the date an employee's employment is terminated. Various written reports also must be filed with SORM. This is discussed more fully later in the handbook.

> US Department of Labor 1910.1020(d)(1)(i)
> Employee medical records. The medical record for each employee shall be preserved and maintained for at least the duration of employment plus thirty (30) years, except that the following types of records need not be retained for any specified period:

Notify SORM Immediately of Hospitalizations or Fatalities

If the injury results in a stay at the hospital or results in death, the agency must immediately notify SORM by telephone, in addition to filing the required first report of injury.

> RULE § 251.212 Immediate Notice of Injury
> "Immediately after the employing agency learns of any serious injury or work-related illness or injury resulting in death to an employee, the employing agency must give notice to the director by telephone. Form DWC-1S must still be filed as required."

Post Required Notices in the Workplace

DWC rules require that an employer who has workers' compensation insurance coverage post certain notices in the workplace (28 Texas Administrative Code 110.101). Please call DWC's Information Services line at 800-252-7031 for more information.

> RULE §110.101 Covered and Non-Covered Employer Notices to Employees
> This Rule, states in part, "(e) Employers shall post notices in the workplace to inform employees about workers' compensation issues as required by this rule. These notices shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis. The notices shall be printed with a title in at least 26-point bold type, subject in at least 18-point bold type, and text in at least 16-point normal type, and shall include ENGLISH, SPANISH, and any other LANGUAGE common to the employer's employee population. The text for the notices shall be the text provided by the division on the sample notice without any additional words or changes.

Inform Employees of the Ombudsman Program

A state agency, as the employer, is required by the Workers' Compensation Act (Act) to inform employees of the Office of Injured Employee Counsel's ombudsman program. The mission of the ombudsman program is to assist injured employees, employers, providers, and beneficiaries claiming death benefits to obtain benefits under the Act. Failure to inform employees of this program may result in an administrative violation.

Develop Health and Safety Programs and Return-to-Work Programs

The Legislature has mandated that all covered agencies have programs in place to promote the health and safety of the employees and to assist injured employees with returning to work. These programs must comply with SORM's *Texas Enterprise Risk Management (TERM) Guidelines*. Return-to-work programs will be a coordinated effort involving the SORM Enterprise Risk department, the employing state agency, and the medical provider. See Section 412.051 of the Texas Workers' Compensation Act or call SORM at (512) 475-1440 for additional information.

Call DWC's Information Services line at 800-252-7031 for more details on these and other DWC requirements.

Employer's Rights

As the employer of record, state agencies are entitled to certain rights under the Texas Workers' Compensation Act. Section 409.011(b) of the Act describes the rights of the employer. These rights include:

1. the services provided by the division and the office of injured employee counsel.
2. the division's procedures; and
3. the employer's rights and responsibilities under this subtitle.
   (a) The information must include a clear statement of the following rights of the employer:
      (1) the right to be present at all administrative proceedings relating to an employee's claim;
      (2) the right to present relevant evidence relating to an employee's claim at any proceeding;
      (3) the right to report suspected fraud;
      (4) the right to contest the compensability of an injury if the insurance carrier accepts liability for the payment of benefits;
      (5) the right to receive notice, after making a written request to the insurance carrier, of:
         (A) a proposal to settle a claim; or
         (B) an administrative or a judicial proceeding relating to the resolution of a claim; and
      (6) the right to contest the failure of the insurance carrier to provide accident prevention services under Subchapter E, Chapter 411.

The division is not required to provide the information to an employer more than once during a calendar year. Please contact DWC's Information Services at 800-252-7031 for more information about the employer's rights and responsibilities.

Employee Responsibilities

An injured employee has legal responsibilities he or she must meet to establish a claim for compensation.

Notify the Employer Within 30 Days
The injured employee must notify supervisory or management personnel about an on-the-job injury not later than the 30th day after the injury occurs, or if the injury is an occupational disease, not later than the 30th day after the employee knew or should have known that the disease might be related to the employment. Texas Labor Code §409.001.

File a Claim Within One Year
The injured employee must file with DWC a claim for compensation (DWC-41) not later than one year after the date of injury, or if the injury is an occupational disease, not later than one year after the employee knew or should have known that the disease was related to the employment. The DWC-41 is sent to the injured employee by DWC upon notification of claim. Texas Labor Code §409.003.

Provide a Written Statement for Work-Related Exposure to Communicable Diseases
HIV Rule 122.4
For the purposes of qualifying for workers' compensation benefits, the law requires that an employee who claims a possible work-related exposure to HIV infection must provide a written statement of the date and circumstances of the exposure. The law also requires the employee to document that, within 10 days after the date of the exposure, the employee was tested for HIV.

Communicable Diseases Rule 122.3
This section applies only to emergency responders. For the purposes of qualifying for workers' compensation benefits, if the employee is an emergency responder, he/she must provide the employer with a sworn affidavit of the date and circumstances of the exposure. The law also requires the employee to document that, within 10 days after the date of the exposure, the employee was tested for the communicable disease.

Senate Bill (SB) 22
The 87th Legislature passed Senate Bill (SB) 22 which adds new Texas Government Code § 607.0545 to create a rebuttable presumption that a severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) or coronavirus disease 2019 (COVID-19) injury or death is considered work-related for certain first responders. Under the law, first responders include detention officers, custodial officers, firefighters, peace officers, and emergency medical technicians. See Brief for Claims Coordinators.

Claims Coordinator Responsibilities

The claims coordinator is responsible for receiving notices of injury from employees, potential information, or inquiry from other stakeholders (i.e., witnesses, relatives, supervisors, co-workers, etc.) and serves as the liaison between an injured employee and SORM. The claims coordinator is responsible for submitting the required injury reports and notices to SORM and collecting statements from witnesses.

The Claims Coordinator Role as Liaison

When SORM receives notice that a state employee has been injured, a SORM adjuster contacts (usually within 24 hours) the injured employee, the employee's physician, and the employing agency. The claims coordinator is the primary point of contact between the adjuster and the agency. An adjuster will call the claims coordinator soon after receiving the injury report to verify that all the information on the report is correct.

Early contact by the adjuster helps establish the facts of the on-the-job injury in complicated cases and aids in prompt medical treatment and payment of benefits that may be due. Early personal contact may also help to determine the possibility of third-party liability.

The adjuster will call the claims coordinator periodically to obtain additional information or to verify that the employee has returned to work. It is important that the claims coordinator immediately notify SORM when the employee has lost time or returns to work. Timely notification ensures that benefits are correctly paid to the employee.

An adjuster may ask for work schedules or other information about the employee's injury that is available from the agency timekeeper or the employee's supervisor. The claims coordinator is responsible for obtaining this information from their agency and providing it to SORM.

The Claims Coordinator Role in Claim Processing

The claims coordinator is responsible for supplying SORM with the appropriate information and forms so that SORM adjusters can properly process claims. There are various forms that the claims coordinator must file with SORM to ensure that the adjuster can manage the claim appropriately and remain in compliance with the law and DWC rules. There are very important time guidelines that must be adhered to when filing these forms. The forms and instructions for processing and submission are summarized in a checklist format in Section VIII of this manual.

Occupational Diseases

The employing agency is required to file an **Employer's First Report of Injury or Illness (DWC-1S)** with SORM for occupational diseases, even if the employee has lost no time from work.

For occupational disease claims with a date of injury occurring on or after September 1, 1995, the injured employee's eligibility for income benefits terminates 401 weeks after the date benefits are first accrued.

> §408.083 "TERMINATION OF RIGHT TO TEMPORARY INCOME, IMPAIRMENT INCOME, AND SUPPLEMENTAL INCOME BENEFITS. (a) Except as provided by Subsection (b), an employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date of injury.

(b) If an employee incurs an occupational disease, the employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date on which benefits began to accrue."

Additionally, "An occupational disease is defined by the Texas Workers' Compensation Act to mean a disease arising out of and in the course of employment that causes damage or harm to the physical structure of the body. This definition includes a repetitive trauma injury." TDI Advisory 96-15

Potential occupational diseases/cumulative injuries may include, but not limited to the following diagnoses:

Dust Disease NOC (All other Pneumoconiosis)	**Mental Disorder**
Asbestosis	Radiation
Black Lung	All Other Occupational Disease
Byssinosis	Loss of Hearing
Silicosis	Contagious Disease
Respiratory Disorder (Gases, Fumes, Chemicals, etc.)	Cancer
Poisoning - Chemical	AIDS/HIV
Poisoning - Metal	VDT-Related Disease
Dermatitis	Mental Stress
	Carpal Tunnel Syndrome
	All Other Cumulative Injuries

Medical Only Claims

When the injured employee has a medical only claim and is not losing time from work, there are four critical forms, (DWC-1S, SORM-29, SORM-74F and SORM-16) that the claims coordinator must submit to SORM, discussed below. However, SORM adjusters may request subsequent forms or additional information if needed.

The **Employer's First Report of Injury or Illness (DWC-1S)** must be received by SORM not later the next working day after the employer is notified (or has actual notice or knowledge) of a work-related injury or occupational disease of an agency employee where professional medical treatment is sought for such injury, or where a death occurs in a work-related injury regardless of medical treatment. The employer must send the DWC-1S to SORM the first time the employer becomes aware that professional medical treatment has been either sought by or provided to the injured employee for the work-related injury even when there is no lost time from work (conversely, the DWC-1S form must also be sent in every case where there is lost time regardless of medical treatment). A copy of the DWC-1S is included in this handbook.

Why "next working day"?

RULE §120.2 Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities (states in part)

"(a) The employer shall report to the employer's insurance carrier each death, each occupational disease of which the employer has received notice of injury or has knowledge, and each injury that results in more than one day's absence from work for the injured employee….(c) The report shall be filed with the insurance carrier **not later than the eighth day** after having received notice of or having knowledge of an occupational disease or death, or not later than the eighth day after the employee's absence from work for more than one day due to a work-related injury.

However, RULE § 251.209 Time Limit on Submitting Form DWC-1S (states in part)
"Form DWC-1S is to be completed and submitted by the employing agency to the director **no later than the next working day after the employing agency receives its first notice of injury** or work-related illness of an employee. This form shall be completed by the employing agency's claims coordinator or designee, and not by the injured employee.

The claimant (a/k/a employee or injured worker) must complete the **Employee's Report of Injury (SORM-29)** immediately after an injury occurs and the form must be received by SORM not later than the fifth calendar day after the filing of the **Employer's First Report of Injury or Illness (DWC-1S)**. The form must be legible and signed and dated by the claimant. In cases where a DWC-1S is not required (i.e., no lost time or no medical treatment), the employer retains the SORM-29 reports in their records.

The **Witness Statement (SORM-74F)** form must be completed for each witness to the injury or incident. The claims coordinator is responsible for collecting the completed forms and making sure that they are completed accurately for every work-related incident regardless of whether there is any medical treatment or lost time. These forms must be received by SORM not later than the fifth calendar day after the **Employer's First Report of Injury or Illness (DWC-1S)** is filed with SORM. In cases where a DWC-1S is not required (i.e., no lost time or no medical treatment), the employer retains the SORM-74 Witness Statement forms in their records.

The claimant must complete the **Authorization for Release of Information (SORM-16)** immediately after sustaining a work-related injury. The claimant must sign and date the form. The form must be received by SORM not later than the fifth calendar day after the **Employer's First Report of Injury or Illness (DWC-1S)** is filed with SORM. In cases where a DWC-1S is not required (i.e., no lost time or no medical treatment), the employer retains the SORM-16 authorization forms in their records.

Lost Time Claims
When an injured employee is losing time from work, there are additional forms that must be submitted to SORM as set out below.

In every case the employer receives notice or knowledge that there is a work-related injury and the employee has lost time as a result of the claimed injury, the **Employer's First Report of Injury or Illness (DWC-1S)** must be received by SORM not later than the next working day after the first notice of injury is reported to the agency, (SORM Administrative Rule § 251.209). A copy of the DWC-1S is included in this handbook.

> **RULE §251.209 Time Limit on Submitting Form DWC-1S**
> "Form DWC-1S is to be completed and submitted by the employing agency to the director no later than the next working day after the employing agency receives its first notice of injury or work-related illness of an employee. This form shall be completed by the employing agency's claims coordinator or designee, and not by the injured employee.

The Employee's Report of Injury (SORM-29) must be completed by the claimant immediately after an injury occurs and should be received by SORM not later than the **5th calendar day** after the filing of the **Employer's First Report of Injury or Illness (DWC-1S)**. The form must be legible, and the claimant must sign and date the form. In cases where a DWC-1S is not required (i.e., no lost time or no medical treatment), the employer retains the SORM-29 reports in their records.

Injured employees must choose whether they will utilize sick leave before receiving workers' compensation income benefits on the **Employee's Election Regarding Utilization of Sick Leave (SORM- 80)**. This form must be

received by SORM not later than the **5th calendar day** after the first full day of lost time.

If the employee experiences one full day of lost time, not including the date of injury, the claims coordinator must submit the **Employer's Wage Statement (DWC-3)** to SORM. This form should be received by SORM not later than the **5th calendar day** after the first full day of lost time.

> RULE §120.4 Employer's Wage Statement
> (a) The employer is required to timely file a complete wage statement in the form and manner prescribed by the commission. As used in this section, the term "filed" means "received."
> (1) The wage statement shall be filed with the carrier, the claimant, and the claimant's representative (if any) **within 30 days** of the earliest of:
> i. the date the employer is notified that the employee is entitled to income benefits;
> ii. the date of the employee's death as a result of a compensable injury.

However, the SORM DWC-3 instructions state, "The form must be received by SORM not later than the **5th calendar day** after the first full day of lost time. This is considered a "best practice" and will assist us in getting the appropriate and timely payments to the injured worker.

The claims coordinator must complete a **Witness Statement (SORM-74)** for each witness to the injury or incident. The claims coordinator is responsible for collecting the completed forms and making sure that they are completed accurately. These forms must be received by SORM not later than the **5th calendar day** after the **Employer's First Report of Injury or Illness (DWC-1S)** is filed with SORM.

The claims coordinator must submit the Supplemental Report of Injury (DWC-6) to SORM for any of the following five different scenarios. Because this information is crucial to the timely stopping and starting of benefits, we request that the claims coordinator call the adjuster as soon as possible and follow up by faxing a DWC-6 to SORM.

- When the employee returns to work, the form must be received by SORM not later than the **third calendar day** after the employee returns to work. (RULE §120.3 Employer's Supplemental Report of Injury)

> RULE §120.3 Employer's Supplemental Report of Injury
> (b) The report shall be filed with the employer's carrier and provided to the employee **within ten days** after the end of each pay period in which the employee has a change in earnings as a result of the injury or within ten days after the employee resigns or is terminated.
> (c) For injuries requiring an Employer's First Report of Injury, unless the information required in this subsection is provided on the Employer's First Report of Injury, the employer shall file the Supplemental Report of Injury with the employer's carrier and provide a copy to the employee **within three days** after:
> (1) the employee begins to lose time from work as a result of the injury;
> (2) the employee returns to work; or
> (3) the employee, after returning to work, experiences an additional day(s) of disability as a result of the injury.

RULE §251.210 Form DWC-6

In case of lost time injury, Form TWCCDWC-6 is to be completed and submitted to the director **immediately** after an injured employee returns to work.

The actual DWC-6 Form instructions, state "This report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

When an employee returns to work and experiences an additional day(s) of disability as a result of the injury, the form must be received by SORM not later than the **third calendar day** after employee loses the first additional day.
If the employee experiences a change in weekly earnings (increase or decrease) after the injury, the form must be received by SORM not later than the **third calendar day** after the end of the pay period in which this occurs.

- If the employee resigns or is terminated, the form must be received by SORM not later than the **third calendar day** after that event.

The claims coordinator must submit the **Notification of Additional Information (SORM-90)** to SORM, not later than the next working day after any additional leave has been granted (extended sick leave, sick leave pool, emergency sick leave, FMLA).

If the employer suspends health insurance, the employer must file a SORM-90 with SORM within three days reporting the date of suspension.

The employer should report the employee's last FULL day of paid leave on the SORM-90 within three days of the employee going leave without pay.

The claimant must complete the **Authorization for Release of Information (SORM-16)** form immediately after sustaining a work-related injury. The claimant must sign and date the form. The form must be received by SORM not later than the **5th calendar day** after the first notice of injury is filed with SORM.

Other Forms
The injured worker must complete the Travel Reimbursement Form (DWC-48) when seeking reimbursement for travel expenses for medical care relating to work-related injuries. This covers authorized reimbursements for mileage, lodging, and meals. The injured worker or claims coordinator must submit this form. It must be received by SORM not later than 30 calendar days after the date of travel. SORM has 45 days to process the DWC-48.

The injured worker must complete a Medical Reimbursement Request (SORM-81) for any out-of-pocket expenses incurred. The adjuster will review the request once it is received. SORM has 45 days to process the SORM-81.

Claims Administration Strategies

There are many things that an agency and the claims coordinator can do to help in managing workers' compensation costs and the amount of lost time for their injured employees. SORM is actively pursuing these goals and is available to assist in achieving them.

Prompt Reporting

Once an injury has occurred, it is important that the injury is reported to SORM immediately. The claims coordinator should work with the supervisors to remind them that early reporting of injuries is crucial to the investigation of the accident, evaluation of the claim, and appropriate management of the claimant's medical care. Prompt reporting of injuries will ensure that proper medical care is started quickly and will assist the claims adjuster in starting benefits in a timely manner.

It is also important that the claims coordinator timely reports to SORM when an injured employee returns to work. Supervisors need to relay this information immediately, along with information about sick and annual leave used to prevent overpayment of income benefits.

Frequent Contact with the Employee

Studies show that frequent contact with injured workers can help to return them to work sooner than if there is no contact. When the employee feels that their employer is concerned about their recovery, they will mentally recover sooner and be more likely to return to work. SORM recommends that claims coordinators call each injured employee once a week to keep records up to date and to keep the employee informed on agency happenings. Claims coordinators should also encourage employees' supervisors to call injured workers about returning to work. Please refer to SORM's Texas Enterprise Risk Management (TERM) Guidelines.

Return-to-Work Programs

SORM is a valuable resource that assists in assessing health and safety risks and makes risk control recommendations to eliminate and/or reduce losses; however, some accidents and injuries will occur. When an injury occurs, it is then incumbent upon state agencies to help the injured employee to return to work as soon as possible.

Several state agencies and private companies have had success with structured return-to-work programs. A successful program can greatly benefit both employees and state agencies. These programs involve maintaining frequent contact with the employee and medical provider, providing a modified work environment and/or work assignment, or providing alternate-duty assignments that return the employee to the workplace within his or her temporary medical restrictions. These measures assist the employee in maintaining a positive attitude and reduce the costs associated with a lengthy absence from work.

Return-to-work programs allow injured employees to work within their abilities and within temporary medical restrictions. During this time of work restriction, the employee is said to be on modified or alternate duty. The employee may be doing their regular job with modification, or they may be assigned alternate responsibilities unrelated to their usual job. Along with programs aimed at loss prevention and loss reduction, the return-to-work program can lower the agency's workers' compensation costs and reduce the necessity to hire additional staff. Providing the injured worker with an opportunity to return to the workplace in a productive capacity will encourage the worker to return to their regular position much sooner. Although some job modifications and/or accommodations may need to be made, many positions can be modified with very little expense.

Please refer to SORM's guidelines regarding return-to-work programs in Texas Enterprise Risk Management (TERM) Guidelines, Chapter 30.

Each agency's Americans with Disabilities Act (ADA) coordinator may also have additional information on the topic of reasonable accommodations for persons with disabilities as defined by the ADA.

Health & Safety, Wellness, and Risk Management Programs

The Legislature has mandated that state agency risk management programs, health and safety programs, and return-to-work programs must be developed and implemented in accordance with SORM's guidelines, per Section 412.051, Texas Workers' Compensation Act. These programs must be approved by SORM.

Bona Fide Offers of Employment (BFOE)

A bona fide offer of employment is a written offer of employment delivered to an employee during the period for which benefits are payable. Bona fide offers of employment should be made once the employee has been released to modified duty as reported on the **Work Status Report (DWC-73)** form by a doctor, physician assistant or advanced practice registered nurse. Bona fide offers of employment can greatly reduce a claim's cost by getting employees back into the workplace to perform duties not likely to impede recovery from their injuries. Workers are likely to return to their full-time positions more quickly if they take on a modified-duty job rather than staying home. Claims coordinators must coordinate bona fide offers of employment with their agency's human resources staff.

The written Bona Fide Offer of Employment must clearly state the following:

1. The position offered (to include the duration of the offer);
2. The duties of the position;
3. That the employer is aware of and will abide by the physical limitations under which the treating physician has authorized the employee to return to work;
4. The maximum physical requirements of the job;
5. The wage;
6. The location of employment and work schedule;
7. The training that will be provided, if necessary, for the position
8. being offered; and
9. Include an attached copy of the signed DWC-73 on which the offer is based.

DWC considers the following items when determining whether an offer of employment is bona fide:

1. The manner in which the offer was communicated to the employee;

The physical requirements and accommodations of the position compared to the employee's physical capabilities; and

2. The distance of the position from the employee's residence.

Employment is "geographically accessible" to the injured employee if it is within a reasonable distance from the employee's residence unless the employee proves with medical evidence that their physical condition precludes traveling that distance.

If the employee returns to work or is cleared for the work by their physician but refuses to accept the work, income benefits may be suspended.

Always send the adjuster a copy of the letter when the letter is mailed and when an employee's response is received.

The following two pages contain a sample letter for a BFOE and the sample instructions that should be sent along with the letter.

Bona Fide Offer of Employment Sample Instructions

The following sample instructions that should be sent along with the letter.

EMPLOYEE'S INSTRUCTIONS

PLEASE FOLLOW THE INSTRUCTIONS BELOW:
Read carefully the attached letter. If this letter is not clear, please contact our office immediately for clarification.
Submit a copy of this bona fide offer of employment to a physician for their consideration before accepting the offer and/or returning to work.
Please check the appropriate space below indicating acceptance or denial of the offer of employment.
Sign and date the form.

1. Return the letter immediately. A phone call may be made to accept or not accept the position. Refusal to accept the bona fide job offer could result in the termination of your income benefits.

Bona Fide Offer of Employment Sample Letter

The following information should be included in the letter for a bona fide offer of employment. Also, attach a copy of the doctor's restrictions.

CERTIFIED MAIL RECEIPT REQUESTED

Dear (claimant):

Our office is in receipt of medical information from Dr.__outlining the restrictions under which you are able to return to work. Our office will abide by the physical limitations as outlined by the physician. In accordance with Rule 129.6 of the Texas Department of Insurance, Division of Workers' Compensation, the following information is provided to you for consideration as a bona fide offer of employment.
Position title:
Hours of duty:__a.m. / p.m. until _____a.m. / p.m.
Wages: $_____Hourly $_____Weekly $_____Monthly
Job description, including duty hours, and maximum physical requirements of the position (lifting and approximate lbs.; approximate time stooping, pushing, standing, sitting, etc.):

1. Address, location, and duty hours of the offered position and approximate distance in miles from employee's residence:

If necessary, training will be provided for the temporary assignment. Should you have any questions, please contact the undersigned below.

Sincerely,

At the bottom of the letter, the claimant should be required to fill out the following information.

Claimant:

_____ I have read and understand the requirements of the position and accept the position.

_____ I have read and understand the requirements of the position but do not accept the position.

_____ _____
Signature Date Signed

Utilization of Sick and Annual Leave

Under the state employee's workers' compensation system, an injured state employee has the option of using accrued sick leave and accrued annual leave instead of receiving lost-time compensation benefits.

Since the amount of lost-time benefits is usually less than an employee's salary, the advantage in making such an election is that the employee will receive his or her full paycheck during the period that accrued sick leave or accrued annual leave is utilized. With this election, the employee's insurance premium is paid at 100%.

An employee may elect to use all accrued sick leave and all accrued annual leave; all accrued sick leave and a portion of accrued annual leave; all accrued sick leave and no accrued annual leave; or no accrued sick leave and no accrued annual leave. Accrued sick leave must be exhausted before accrued annual leave can be used. These are the only available elections. *See* Texas Labor Code §501.044.

"Sick leave" includes sick leave regularly earned and accumulated by the employee because of employment with the state, extended sick leave with pay authorized by the administrative head(s) of any state agency, and sick leave with pay granted to the employee from any sick leave pool.

"Annual leave" includes paid vacation earned and accumulated by the employee because of employment with the state.

Sick and annual leave that is accumulated while an injured employee is off work cannot be utilized until the injured employee returns to work and has subsequently lost time due to the injury.

Appropriate forms for making an election to use sick leave and for notification of the granting of extended sick leave and pooled sick leave can be found in the forms section of this handbook.

For further information on state employee use of sick leave under workers' compensation benefit requirement see the SORM rules at 28 Texas Administrative Code Subchapter C §§ 301 – 309.

Third Party Liability

When an employee sustains a work-related injury, recovery of workers' compensation benefits is the employee's exclusive remedy against the employer. However, when an employee is injured in the course and scope of employment as a result of a negligent third party, for example when the employee is in a motor vehicle accident and the other driver is 100% at fault or equipment with a manufacturers defect, the employee has the right to pursue a claim against the third party in addition to pursuing a workers' compensation claim.

When an employee covered by workers' compensation insurance is injured as the result of a negligent third party, SORM is subrogated to the rights of the injured employee or legal beneficiary and may seek to recover medical and compensatory benefits paid to or on behalf of the injured employee. In a case of third-party liability, at the time an injured employee files a claim for workers' compensation benefits, the workers' compensation insurer's right to subrogation is automatically established under Texas Labor Code Chapter 417. However, recovery does not mature until the first dollar of benefits has been paid to or on behalf of the injured employee.

Texas law entitles SORM to first and full reimbursement from any third-party settlement, up to the amount of the lien. This means that if either the injured employee or SORM pursues the claim and recovers money from the negligent third party, either by a settlement agreement or through the courts, the first money must be applied to reimburse SORM for the workers' compensation benefits that have been paid to or on behalf of the injured employee. Moreover, SORM is entitled to treat the injured employee's net recovery as an advance against any future workers' compensation benefits that the injured employee may be entitled to under the Workers' Compensation Act.

An employee who is injured as the result of a negligent third party cannot conspire by settlement, release, or apportionment of damages to deprive SORM of its right to reimbursement for benefits paid. When an injured employee and a negligent third party enter into settlement, "both" are liable to SORM for benefits paid. Further, the Texas Supreme Court has held that an injured employee has no cause of action against a third party except to the degree his or her damages exceed the workers' compensation recovery.

The rationale for subrogation in workers' compensation is to prevent double recoveries by an injured employee to keep rates lower and to permit SORM to recover some of the taxpayers' money. As such, SORM has established a Subrogation Unit, within the Office of the General Counsel, to actively pursue these claims. The Subrogation Unit reviews every DWC-1S filed with SORM for potential subrogation activity.

Adjusters and claims coordinators can play a significant role in the identification of potential workers' compensation insurance carrier subrogation recovery claims by collecting as many facts as possible about the way the accident or injury occurred. These facts should then be sent to the Subrogation Unit in a timely manner. Consultation with the SORM Subrogation Unit should be utilized whenever a claims coordinator identifies a potential claim for third-party subrogation liability. The rule is to never assume unknown facts where potential for third-party subrogation liability may become an issue.

Among the most important things to do in a third-party liability subrogation claim is to ensure that the evidence from the accident is preserved. Claims coordinators should work with safety officers to secure defective or malfunctioning equipment for investigation by SORM.

Photographs of the accident scene should be taken immediately following the incident to preserve "first impression" and permanent evidence before the evidence is moved, cleaned or otherwise altered from its

immediate post-accident state, condition or position. A severe injury where court action is involved may take years to settle and, during that time, injuries heal, memories will fade, and witnesses move or otherwise become unavailable.

Claims coordinators should provide a very thorough written description of the incident. They should also obtain witness statements and interview all witnesses as soon as possible while the details of the accident are still fresh on their minds. Claims coordinators should provide information about outside contractors or companies where there may be a direct connection to the incident. For instance, janitorial services, construction crews, and delivery people may be responsible for a slip and fall, premise liability, or product liability injury. A complete and thorough investigation will save time and money in a subrogation action.

This section contains two checklists which will play an important part in the daily activities of a claims coordinator. The Claims Coordinator Checklist details which forms must be sent to SORM and when and how to submit them.

1. The Subrogation Checklist highlights some of the important information that a claims coordinator can obtain to assist us in our third-party liability investigations.

We recommend that you make copies of these two checklists and use one for every new claim as applicable.

Claims Coordinator Checklist

This checklist is intended to outline the responsibilities of the Claims Coordinator regarding filing the proper forms to SORM within the appropriate time frames.

Form Title	When to File	How to File	Completed
Employer's First Report of Injury or Illness (DWC-1S)	Not later than **the fifth calendar day** after receiving knowledge of: a) a work-related disease, illness, or death; b) medical expenses incurred due to a work-related injury; or c) an employee's absence from work due to a work-related incident or injury.	Online entry under SORM's RMIS Copy to employee with Rights and Responsibilities	☐
Health Care Network Acknowledgement Form	Not later than **three working days** after submitting a DWC-1S in the event of an injury where the employee must seek urgent attention, have them sign the acknowledgment form and send it to SORM immediately.	Mail, fax, or email, to SORM	☐
Employee's Report of Injury (SORM-29)	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail, fax, or email, to SORM	☐
Witness Statement (SORM-74) one for each witness	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail, fax, or email, to SORM	☐
Authorization for Release of Information (SORM-16)	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail, fax, or email, to SORM	☐
Employer's Wage Statement (DWC-3)	Not later than **the fifth calendar day** after: a) Filing a DWC-1S b) An employee's absence from work due to a work-related incident or injury; or c) a request from SORM.	Online entry under SORM's RMIS Copy to employee	☐

Form Title	When to File	How to File	Completed
Employee's Election Regarding Utilization of Sick and Annual Leave (SORM-80)	Not later than **five calendar days** after any time missed from work due to the work-related injury	Mail, fax, or email, to SORM	☐
Supplemental Report of Injury (DWC-6)	Must be received by SORM not later than **the third calendar day** after employee: a) is unable to work; b) returns to work; c) the end of each pay period in which the employee has a change in earnings; or d) dies, resigns, or is terminated	Online entry under SORM's RMIS copy to employee	☐
Notification of Additional Information (SORM-90)	Must be received by SORM not later than **one working day** after any change occurs, i.e., additional leave is granted (extended sick leave, sick leave pool, emergency sick leave, FMLA) or health insurance is suspended	Online entry under SORM's RMIS	☐

Subrogation Checklists

The following checklists are a guideline for the claims coordinators to use when there is an injury that could involve subrogation or third-party liability. Three of the most common third-party liability situations resulting in an injury are as a result of motor vehicle accidents, dangerous or defective products, devices, or conditions of the premises. The following lists are not all-inclusive but contain information that will be vital in a subrogation investigation. The claims coordinator can assist by gathering any available information.

Motor Vehicle Accidents

Item	When to File	Where/How to File	Completed
Obtain a Witness Statement (SORM-74) from each witness.	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail or fax a copy to SORM	☐
Obtain copies of any internal investigation reports about the incident.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐
Provide a detailed description of the accident scene - location, traffic signals/signs, road construction, etc., if the police did not write a report.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐
Provide names of all parties involved in the accident if the police did not write a report.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐
Provide insurance coverage for each vehicle involved in the accident, if the police did not write a report.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐
Provide police reports from the accident.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐

Item	When to File	Where/How to File	Completed
Provide names of owners of vehicles involved in the accident, if the police did not write a report.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐
Provide the year, make, and model of the vehicles involved in the accident, if the police did not write a report.	Submit within two weeks of the accident.	Mail or fax a copy to SORM	☐

Product Liability

Item	When to File	Where/How to File	Completed
Secure the actual product or piece of equipment with no modifications or repairs and store for future investigation by SORM.	Secure the product or piece of equipment immediately.	SORM RM Rep. will visit the site to view.	☐
Obtain a Witness Statements (SORM-74) from each witness.	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail or fax a copy to SORM	☐
Obtain copies of any internal investigation reports about the incident.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Obtain names of all parties involved in the incident.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide information about the product or equipment involved in the incident - name, model, manufacturer, distributor, intended use, purchase date, the original purchase order for the product or equipment, etc.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide a detailed description of the incident - location, nature of the activity, etc.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Describe any modifications made to the product or equipment since the purchase plus who performed them and when.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Determine how long the product or equipment has been in use and whether it was used in accordance with manufacturer's guidelines at the time of the incident. Also, determine if any safety equipment was used at the time of the incident, and whether it was required in order to operate the equipment or product.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide available maintenance records of the equipment.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide photographs of the product or equipment.	Submit within two weeks of the incident.	Mail a copy to SORM	☐

On/Off Premises Injury (slip, fall, etc.)

Item	When to File	Where/How to File	Completed
Obtain a Witness Statements (SORM-74) from each witness.	Not later than **the fifth calendar day** after submitting a DWC-1S	Mail or fax a copy to SORM	☐
Obtain copies of any internal investigation reports about the incident.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Obtain names of all parties involved in the incident.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide a detailed description of the incident - location, nature of the activity, etc.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide the name of the building owner.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide the name of tenant/leaseholder.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide insurance coverage of third parties involved (owner, tenant, builder, etc.).	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide the name of the architect who designed building.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide the name of contractors and subcontractors who constructed the building.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide maintenance service records - type of service, dates, and who performed.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide the name of janitorial service for the building.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide names of any third parties recently at that location, such as repair persons.	Submit within two weeks of the incident.	Mail or fax a copy to SORM	☐
Provide photographs of the incident location.	Submit within two weeks of the incident.	Mail a copy to SORM	☐

Forms

Links and examples of the following required forms are provided herein. All forms are available on the Claims Coordinator Resources page on the SORM website, or through SORM's online system, RMIS. Forms from the Division of Workers' Compensation (DWC) can also be found on the DWC website.

PLEASE USE THE CURRENT ONLINE FORMS ONLY.

DO NOT USE THE EXAMPLES PROVIDED IN THIS MANUAL.

Employer's First Report of Injury or Illness (DWC-1S)

Login to RMIS to complete the DWC-1S

Required:
Form DWC-1S must be completed and submitted to SORM for any on-the-job injury that:

- Has more than one day of lost time;
- Is an occupational disease, with or without lost time or medical expenditures;
- Resulted in the death of the employee; or
- Results in expenditures for medical treatment or service.

It is important that every box be completed on the DWC-1S form. Incomplete or missing data often prevents efficient processing of the DWC-1S and can prevent injured employees from receiving benefits in a timely manner. If a box is not applicable, fill it in with N/A.

PLEASE NOTE: **If an on-the-job injury is not an occupational disease, does not result in medical treatment, does not result in the death of the employee or results in less than one day of lost time, the employer will keep the record in their employer files only.**

Filing Deadline:
In claims where there is either one day of lost time, medical treatment or an occupational disease, the form must be received by SORM not later than the next working day after the employing agency is first notified or receives knowledge of the injury or illness.

PLEASE NOTE: **When an employee suffers a severe or fatal injury, please contact SORM by phone and submit the form immediately.**

Completed by:
The claims coordinator.

Instructions:
PLEASE COMPLETE ALL APPLICABLE FIELDS. Most fields are self-explanatory; however, the following items may require more attention:

Item 4:	If no home phone, please give a phone number where the employee can be reached.
Item 7:	Employees work phone number.
Item 8:	This information is no longer required.
Item 13:	This information should include the doctor's telephone number.
Item 15:	This should be the actual date of injury, or (for occupational diseases) the date the employee knew or should have known the condition was work-related.
Item 17:	This should be the first full day of lost-time from work. (Please note that the date of injury is not considered the first day of lost time.) Mark NLT or N/A if there is no lost time.
Item 18:	List the nature of the injury. Examples include: burn, cut, or sprain.

Item 19:	List specific body part, which side of body is affected, e.g., chin, **right** leg, **left upper** arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail. Use additional sheet of paper if necessary.
Item 24:	This should state the specific substance or exposure that directly inflicted the injury such as a tool, chemical (list the name of the chemical), or machine.
Item 26:	The date should be entered even if the employee has returned to work even for a portion of the day. If the employee has returned to work making less than his or her pre-injury wage, a DWC-6 must also be submitted.
Item 28:	This is the employee's immediate supervisor. Please include a work telephone number.
Item 29:	This is the date the employee reported the injury to the employer as work related.
Item 34:	This 4-digit code corresponds to the primary occupation in which the employee was engaged at the time of the injury or exposure. This code is from the state job description table and is available from the State Comptroller of Public Accounts.
Item 43:	This 9-digit code represents the location of the agency unit that employed the injured worker at the time of their injury or exposure. The first three digits will be 100 for state agencies or 200 for county entities. The second three digits are the agency code. The third three digits are the location code as established by each agency. Contact the SORMs Risk Assessment and Loss Prevention section for information about or changes to your agency location code(s).
Item 44:	This 9-digit code is assigned to each agency by the Internal Revenue Service for employment, tax, and reporting purposes.
Item 45:	This 4-digit code is assigned to each agency and represents the nature of the employer's business. For specific questions about Primary Standard Industrial Classification (SIC) codes, call the Texas Workforce Commission (TWC).
Item 46:	This may be the same as the last item if the agency has one primary SIC code. If there is more than one, this should be the SIC code specific to the job being performed. If in doubt, call the TWC.
Item 47:	This is the state agency code number assigned by the State Comptroller of Public Accounts.
Item 51:	This must be the signature and title of the claims coordinator. If signed by someone other than the claims coordinator, he or she must list his or her title and state that it was signed for the claims coordinator. The date must also be included.
Item 52:	Enter the number of sick/annual leave hours credited to the employee as of the date of injury.

Distribution:
Submit online to: State Office of Risk Management Mail a copy to the claimant.
Retain a copy for your file.

Mail this form to:
STATE OFFICE OF RISK MANAGEMENT
P. O. Box 13777
Austin, Texas 78711

Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

CLAIM #

SORM CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) | 2. Sex F ☐ M ☐ | 16. Date of Injury (m-d-y) | 16. Time of Injury am ☐ pm ☐ | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone ( ) | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐ | 20. How and Why Accident/Injury Occurred*

7. Employee Telephone # | 8. Block no longer used | 21. Was employee doing his/her regular job? YES ☐ NO ☐ | 22. Worksite Location of Injury (store, dock, etc.)*

9. Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

City State Zip Code County | Street or P.O. Box County City State Zip Code

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury (fall, tool, machine, etc.)*

13. Doctor's Name Telephone # | 25. List Witnesses (Name, Telephone #

14. Doctor's Mailing Address (Street or P.O.Box) | 26. Return to work date (m-d-y) | 27. Did employee die? YES ☐ NO ☐ | 28. Supervisor's Name | 29. Date Reported (m-d-y)

City State Zip Code

30. Date of Hire (m-d-y) | 31. Was employee hired or recruited in Texas? YES ☐ NO ☐ | 32. Length of Service in Current Position Years ____ Months ____ | 33. Length of Service in Occupation Years ____ Months ____

34. State Payroll Classification Code | 35. Occupation of Injured Worker

36. Rate of Pay at this Job $____ Hourly $____ Weekly $____ Monthly | 37. Full Work Week is ____ Hours ____ Days | 38. Last Paycheck was: $____ | 39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form Claims Coordinator | 41. Name of Agency

42. Agency Mailing Address and Telephone Number Street or P.O. Box Telephone ( ) City State Zip Code | 43. Agency Location Code ____ ____ ____ / ____ ____ ____ / ____ ____ ____ Name of Location: ____

44. Federal Tax Identification Number | 45. Primary North American Industrial Classification System Sector Code (NAICS) (2 digits) | 46. Specific NAICS Code | 47. Comptroller Agency Code

48. Workers' Compensation Insurance Company: **State Office of Risk Management** | 49. Policy Number: **TXSTATEPOL001**

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐ | 52. Number of Hours of Sick/Annual Leave Credited to Employee on Date of Injury

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

DWC FORM-1S (Rev. 10/05) Page 1 DIVISION OF WORKERS' COMPENSATION

DWC-1S Violation Rule

Employers have important responsibilities under the Workers' Compensation Act. Along with health care providers, they are a primary source of information for the carrier to use to administer claims. Without the employers' and health care provider's assistance, carriers are hard pressed to timely and appropriately deliver benefits to injured employees. Failure to provide complete andtimely information will result in penalties that can be quite substantial. A state agency is the employer and has a duty under the Texas Workers' Compensation Act to timely and accurately provide information to the State Office of Risk Management (insurance carrier) so that injured employees can receive the benefits they are entitled to. Although many employees use accumulated leave as a form of salary continuation for injuries, this does not remove the employers' responsibilities with regard to reporting.

DWC-1, Employer's First Report of Injury
Texas Labor Code §409.005, §415.021 and DWC Rule 120.2

The Employers' First Report of Injury must be filed within 8 days of the date the employer received notice of the injury or an occupational disease, or the 8th day after the employee's absence for more than one day from work due to the injury or death. Rule §120.2

Failure to timely report the lost time in this manner may be subject to an "administrative penalty shall not exceed $25,000 per day per occurrence. Each day of noncompliance constitutes a separate violation. §415.021Texas Labor Code §415.021.

Do not send this form to the DWC, unless specifically requested to do so.

If a report has not been received by the carrier, SORM, the employer has the burden of proving that the report was filed within the required time frame.

This report may not be considered as an admission or evidence against the employer or the insurance carrier in any proceeding before the DWC or a court in which facts set out in the report are contradicted by the employer or insurance carrier. Texas Labor Code §409.005(f).

Employer's Wage Statement (DWC-3)

Login to RMIS to complete the DWC-3

Required:
Immediately after receiving notice of an injury, the agency should complete the employee's wage statement. This information is needed when the employee experiences one (1) or more full days of lost time or as requested by SORM.

If a fringe benefit is identified as being continued, and the employer later suspends that benefit, the employer must file an amended DWC-3 form with SORM within three (3) calendar days of reporting the date of suspension.

Filing Deadline:
The form must be received by SORM not later than the 5th calendar day after the first full day of lost time.

Completed by:
The claims coordinator or agency representative.

Instructions for the DWC-3 (Sample Provided):
Please follow these steps when completing the Employer's Wage Statement (DWC-3) form. A sample form is also included for your reference.

First, indicate whether the DWC-3 is being submitted for the first time or if it is an amendment to a previously submitted DWC-3 by placing an "X" in either the "Initial" box or the "Amended" box.

STEP ONE: EMPLOYER AND EMPLOYEE INFORMATION
Boxes 1-9 are self-explanatory.
Box 10: Indicate the employee's status according to the guidelines included on the form.

STEP TWO: SAME OR SIMILAR EMPLOYEE
If the employee was not employed by the agency for 13 continuous weeks before the date of injury, the claims coordinator shall base the injured employee's wages on an employee performing similar services. If using a similar employee, put a check in the appropriate box.

STEP THREE: WAGE INFORMATION - BOX 11
Provide all wage information for each week in the 13 weeks immediately preceding the date of injury. Do not include the date of injury or any days after the date of injury. Earnings to be included under "Gross Weekly Pay" are: Benefit Replacement Pay, Longevity Pay, Hazard Pay, Sick or Annual Leave Paid, and Shift Differential Pay. Do not include any fringe benefits in these calculations. Follow the instructions included on the DWC-3 for boxes 11a, 11b, and 11c.

Employees hired by the State of Texas on or before August 31, 1995, may be eligible for Benefit Replacement Pay (BRP), beginning with wages paid on January 1, 1996. The 74th Legislature eliminated the provision for the State to pay a portion of the employees' share of Federal Insurance Contribution Act (FICA) taxes, commonly referred to as state-paid social security. The BRP is intended to compensate employees for the loss of the state-paid share. New employees hired on September 1, 1995, or later, are not eligible for the BRP.

The formula for calculating Gross Weekly Pay is:

- Monthly Gross Wages ÷ 4.34821 = Gross Weekly Pay

Examples for Wage Information - Box 11:
The following are examples of how to complete Box 11. The sample form illustrates these boxes.

Employee John Doe was injured on 8/12/96 after falling off a warehouse ladder. John had a Monthly Gross Wage of $1,300. John was a full-time state employee and worked Monday through Friday. To calculate his wages, take the following steps:

Box 11a:	Fill in the dates for all 13 weeks prior to the date of injury, starting with the date before the injury occurred.
Box 11b:	Fill in the number of hours paid for all 13 weeks prior to the date of injury, starting with the date before the injury occurred.
Box 11c:	Calculate the Gross Weekly Pay by dividing the Monthly Gross Wages by 4.34821.
	$1,300 ÷ 4.34821 = $298.97

Employees' wages will sometimes change at the end of a month, midway through a work week. In this example, John received a $100 / month raise beginning August 1, 1996, which fell on a Thursday. This is Week 2 on the sample form. Take the following steps to calculate Gross Weekly Pay when two different Monthly Gross Wages combine during one work week:

- Calculate the Daily Wage of the worker for both monthly salaries. To do this, first calculate the Gross Weekly Pay for both Monthly Gross Wages as usual.

Previous Monthly Gross Wage ÷ 4.34821 = Previous Gross Weekly Pay John's Previous Gross Weekly Pay: $1,300 ÷ 4.34821 = $298.97
New Monthly Gross Wage ÷ 4.34821 = New Gross Weekly Pay John's New Gross Weekly Pay: $1,400 ÷ 4.34821 = $321.97

- Divide the Gross Weekly Pay of each salary by the number of days worked each work week to obtain the Daily Wage.

Previous Gross Weekly Pay ÷ 5 days worked = Previous Daily Wage John's Previous Daily Wage: $298.97 ÷ 5 = $59.79
New Gross Weekly Pay ÷ 5 days worked = New Daily Wage John's New Daily Wage: $321.97 ÷ 5 = $64.39

- Add the number of days worked under the Previous Daily Wage to the number of days worked under the New Daily Wage and the total will be the Gross Weekly Pay for that week.

John worked Monday - Wednesday, July 29, 30, and 31: 3 days John worked Thursday - Friday, August 1 and 2: 2 days Previous Daily Wages + New Daily Wages = Gross Weekly Pay
($59.79 x 3 days) + ($64.39 x 2 days) = Gross Weekly Pay
$179.37 + $128.78 = $308.15

John's Gross Weekly Pay is $308.15 for Week 2, July 29 - August 4, 1996.
Use John's new Monthly Gross Wage of $1,400 to calculate the Gross Weekly Pay for Week 1, August 5 - 11, 1996.
$1,400 ÷ 4.34821 = $321.97

STEP FOUR: FRINGE BENEFITS - BOX 12
Do not include fringe benefits in Box 11 calculations. However, always use the injured employee's fringe benefits in Box 12, even if the wages are based on those of a similar employee.

Box 12a:	If the injured employee is entitled to any of the fringe benefits listed, the claims coordinator should check "YES" in the appropriate box.
Box 12b:	State the value or dollar amount of the benefit(s) paid each week prior to the injury. When provided with a monthly amount of benefits paid, divide the monthly amount by 4.34821 for the weekly fringe benefit. Please give the amount of the state contribution for health insurance, not the total charge for health insurance. Do not include employee contributions. Please note that the state contribution for health insurance can be affected by the Family Medical Leave Act. Check with your human resources office if in doubt of any benefits.
Box 12c:	Indicate whether the employer will continue to provide the fringe benefit(s).
Box 12d:	Indicate the date the fringe benefit(s) were or will be suspended.
***	**If a fringe benefit is identified as being continued, and the employer later suspends that benefit, the employer must file an amended DWC-3 form with SORM within three (3) calendar days of reporting the date of suspension.**

Example for Box 12 - Fringe Benefits
John Doe received a state contribution of $176.93 a month for health insurance. To convert this figure to a weekly amount, use the following formula:

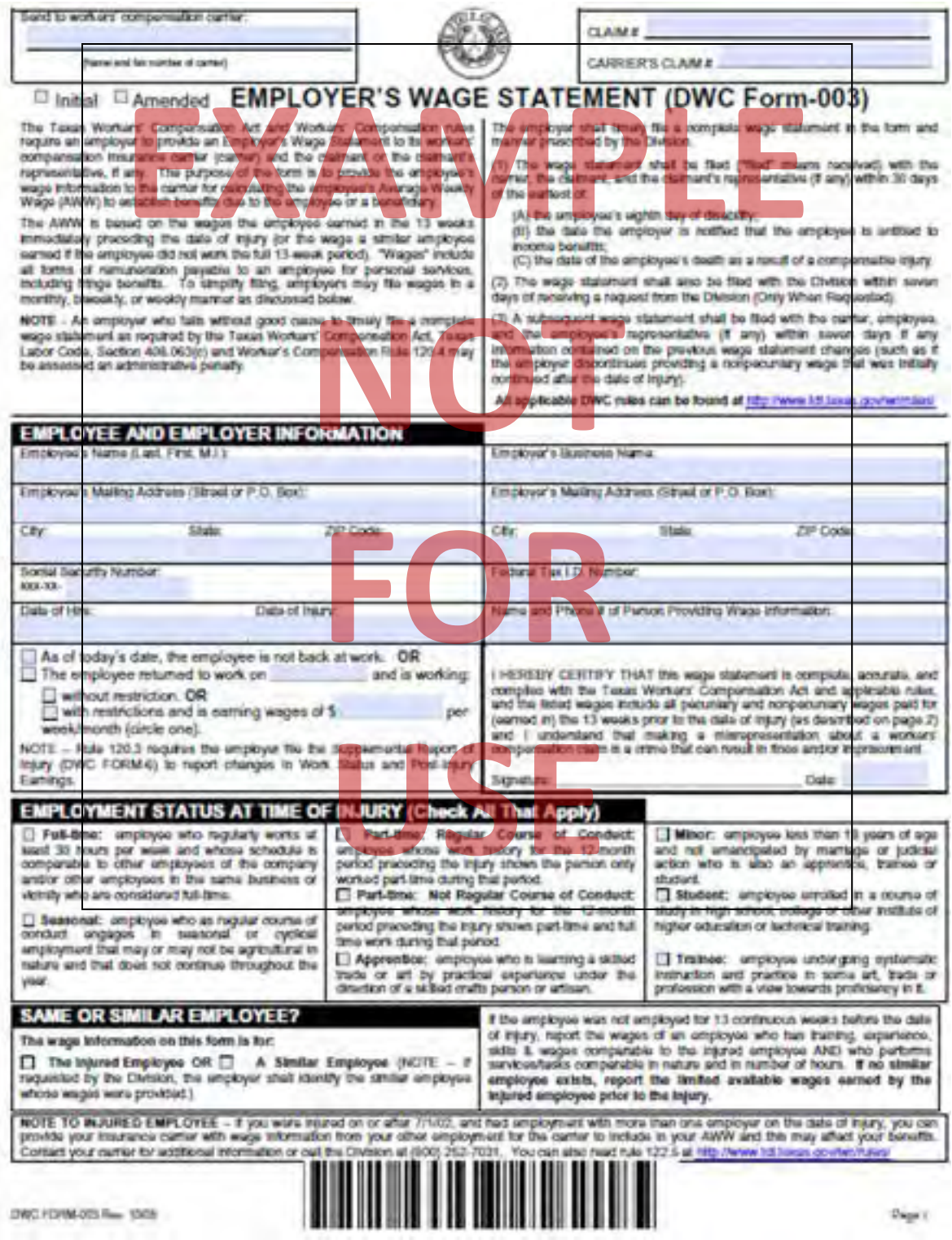
Monthly Fringe Benefit Amount ÷ 4.34821 = Weekly Fringe Benefit Amount
$176.93 ÷ 4.34821 = $40.69/week

Write the figure "$40.69" for all 13 weeks in Box 12b beside the Health Insurance box.

In situations where a Monthly Fringe Benefit Amount changes at the end of a month, midway through a work week, please follow the same steps as illustrated for changing wages at the end of the month.

STEP FIVE: SIGN THE FORM
The Employer's Wage Statement (DWC-3) form must be signed and dated by the person completing the form.

Distribution:
Submit online to: State Office of Risk Management Mail a copy to the claimant.
Retain a copy for your file.



Send to workers' compensation carrier:

(Name and fax number of carrier)

CLAIM #

CARRIER'S CLAIM #

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an employee's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE – An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 122.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employee discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at http://www.tdi.texas.gov/wc/rules/

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. OR
☐ The employee returned to work on _____ and is working:
- ☐ without restriction, OR
- ☐ with restrictions and is earning wages of $ _____ per week/month (circle one).

NOTE – Rule 129.5 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee** OR ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/

DWC FORM-003 Rev. 10/08

Page 1

EXAMPLE NOT FOR USE

WAGE INFORMATION INSTRUCTIONS

Employee Name: | Social Security #: | Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When selecting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly etc. wages; salary; tips/gratuities; premium compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits.**

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned In Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

DWC FORM-003 (Rev. 10/05) Page 2

Send to workers' compensation carrier and the Division:

(name and fax# of carrier)

CLAIM #

CARRIER'S CLAIM #

☐ Initial
☐ Amended

EMPLOYEE'S MULTIPLE EMPLOYMENT WAGE STATEMENT (DWC Form-003ME)

If an employee injured on or after July 1, 2002 worked for more than one employer on the date of injury, the employee's Average Weekly Wage (AWW) may include wages earned from employers other than the employer where the injury/illness occurred. The AWW in this situation is the sum of the AWWs based upon the wages from each employer.

Claim Employer – Employer for whom the injured employee was working at the time of the on-the-job injury.

Non-Claim Employer – Employers other than the claim employer in which the injured employee was employed at the time of the on-the-job injury.

To report wages from other employers, file this form with the carrier and the Division and attach supporting documentation.

NOTICE: With few exceptions, you as an individual are entitled to request and review information that DWC has collected on its forms about you and are entitled to have DWC correct information about you that is incorrect.

Requests for these services must be submitted in writing to OpenRecords@tdi.texas.gov or to:

Open Records
Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104

An applicable DWC rules can be found at http://www.tdi.texas.gov

EMPLOYEE INFORMATION

Employee's Name (Last, First, M.I.):

Employee's Mailing Address (Street or P.O. Box):

City: State: ZIP Code:

Claim Employer Name: Social Security Number: xxx-xx

Date of Injury: Were you working for the Non-Claim Employer on the date of injury? ☐ YES ☐ NO

I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and I understand that making a misrepresentation regarding a workers' compensation injury is a crime that can result in fine and/or imprisonment.

Signature: Date:

Name of person submitting form if not employee:

NON-CLAIM EMPLOYER INFORMATION

Non-Claim Employer's Business Name:

Non-Claim Employer's Mailing Address (Street or P.O. Box):

City: State: ZIP Code:

Non-Claim Employer's Federal Tax I.D. Number:

Name and Phone # of Contact Person at Non-Claim Employer:

I HEREBY CERTIFY THAT THIS WAGE STATEMENT is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages only include those **reportable for federal income tax purposes** and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: Date:

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (Note – upon Division request, the employee and/or Non-Claim Employer shall identify the similar employee whose wages were provided)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NON-CLAIM EMPLOYER WAGES (ONLY THOSE THAT ARE REPORTABLE FOR FEDERAL INCOME TAX PURPOSES)

-Indicate the **Gross Wages Reportable for Federal Income Tax Purposes earned in the 13 weeks immediately prior to the date of injury**. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Do not include payments made to reimburse the employee for the use of the employee's equipment or for paying helpers or reimburse travel expenses.

-If the employee is paid on a monthly or semi-monthly basis, the wages earned may be provided for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the wages for the 14 weeks prior to the date of injury may be reported. When setting the periods to report, the reporting periods may be adjusted backwards slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, do not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PERIOD# (Week#, Month#, or Bi-Week#)	1	2	3	4	5	6	7	8	9	10	11	12	13
FROM DATE:													
TO DATE:													
# HOURS WORKED:													
GROSS WAGES EARNED:													

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

DWC FORM-003ME Rev. 04/16

DWC-3 Violation Rule

DWC-3, Employers Wage Statement
Texas Labor Code §408.063 and DWC Rule 120.4

An employer shall file a signed wage statement with the carrier and the employee within 30 days of the date benefits begin to accrue and with the commission within 7 days of receiving a request from the commission. Rule §120.4

Income benefits begin to accrue (become due and payable) on the eighth day of disability (eight day of total of lost time as a result of the work-related injury). Rule 124.7.

An employer that fails to file a complete wage statement as required by this rule without good cause may be assessed an administrative penalty, not to exceed $25,000 per day per occurrence. Texas Labor Code §415.021.

Employee's Report of Injury (SORM-29)

Download the SORM-29

Required:
This form should always be filled out by the injured employee and filed with SORM. This will help to expedite benefits in a more timely manner.

Filing Deadline:
The form must be received by SORM not later than the 5th calendar day after the First Report of Injury or Illness (DWC-1S) is reported to the agency.

Completed by:
The claimant, with assistance from the claims coordinator.

Instructions:
All fields should be completed in detail and printed legibly. Make sure that the claimant signs and dates the bottom of the form.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management Retain a copy for your file.

SORM
State Office of Risk Management

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ Social Security: _____ Gender: ☐M ☐F
Last First M.I. Maiden

Address: _____ Date of Injury: _____

City: _____ State: ____ ZIP: ____ Employer: _____

Primary Phone Number: _____ Job Title: _____

Secondary Phone Number: _____ Work Schedule: _____

Email address: _____

1) What was the exact location of the accident? Include street address if possible:

2) What was happening at the time? What was going on around you, what were you doing, what were other people doing?:

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date _____ Time _____

Name: _____ Title _____ Phone Number: _____

6) List all known witnesses (continue on back if necessary): 1. Name _____ Phone: _____

2. Name _____ Phone: _____ 3. Name: _____ Phone: _____

7) Who is your Primary Care Physician or family doctor? Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

9) Has a doctor taken you off work? ☐ Yes ☐ No If Yes, when was the first day you missed work? _____

10) If the doctor took you off of work, have you returned to work? ☐ Yes ☐ No If No, when do you think you will return to work? _____

11) Date of Last Appointment: _____ Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ☐ Yes ☐ No If Yes, please enter injury dates and body parts injured:

By affixing my signature, I attest that all information on this form is accurate and true:

Signature: _____ Date: _____

Employee's Election Regarding Sick and Annual Leave (SORM-80)

Download the SORM-80

Required:
Injured employees must choose whether they will utilize accrued sick leave and accrued annual leave before receiving workers' compensation income benefits. No workers' compensation income benefits will be paid until all elected leave is fully utilized as more fully explained further below. The advantage to using sick and annual leave is that the employee will receive their full, normal pay during the elected leave period. Once elected leave is exhausted the employee will receive what they are due under the workers' compensation statues, albeit without deductions for federal income taxes. When sick leave and/or annual leave expires, please notify SORM within two (2) calendar days of the expiration of that leave.

All accrued sick leave must be exhausted before accrued annual leave can be used.

Filing Deadline:
The form must be received by SORM not later than the 5th calendar day after the first full day of lost time has occurred. If not received by that date, the employee will be paid under Election II (see below).

Completed by:
The claims coordinator and injured employee.
Enter the employee's name and date of injury in the space provided.

1. *Election 1*. If employees elect to use all of their accrued sick leave until it is exhausted, instead of receiving workers' compensation benefits during that period, employees **must** also choose one of the following:
    a. To use all of their accrued annual leave;
    b. To use a portion of their accrued annual leave (must indicate the number of annual leave hours to be used); or
    c. To use none of their accrued annual leave.

Explain to employees that workers' compensation benefits do not start until the eighth day of lost time. Employees who cannot work for 14 days will then receive retroactive benefits for that seven-day period or any portion of that seven-day period not covered by leave.
Election 2 -- If employees elect to use none of their accrued sick leave and none of their accrued annual leave, the employees must choose Election 2. Explain to employees that workers' compensation benefits do not start until the eighth day of lost time. Employees who cannot work for 14 days will then receive retroactive benefits for that seven-day period.

2. Be sure to fill in the amount of sick leave and annual leave available to the claimant at the time of injury.
3. Have employees include their Social Security Number and **sign the form stating that they understand that they cannot change an election after signing the form**.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management Retain a copy for your file.

EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE
Peace Officers (SORM-80 PO)

Employee's Name: _____ Date of Injury: _____
Employee's SSN: _____ Agency: _____
If you know, how many hours of leave do you have? _____ sick leave _____ annual leave _____

You are not required to use your leave. Texas Labor Code §501.044 allows an injured state employee to elect to use accrued sick and annual leave before receiving income benefits. NOTE: Sick leave must be exhausted before annual leave may be used. Other categories of leave (compensatory leave, holiday leave, administrative leave, etc.) may not be used prior to sick and annual leave.

Select only ONE election, either Election 1, Election 2, or Election 4, below:
Election 3 intentionally omitted.

☐ ELECTION 1
I elect to use all of my accrued sick leave and all, or a portion, or none of my annual leave when I lose time from work due to this injury or illness. I elect to use all of my accrued sick leave **AND (choose A, B, or C below)**:
☐ A) All of my accrued annual leave;
☐ B) A portion of my accrued annual leave, I wish to use _____hours; or
☐ C) None of my accrued annual leave.

☐ ELECTION 2
I elect to <u>not</u> use accrued sick or annual leave. When I lose time from work due to this injury or illness, I elect to not use any accrued sick leave or annual leave. I understand I am not entitled to workers' compensation income benefits until after the seven (7) calendar day waiting period.

☐ ELECTION 4
I elect to use injury leave for Peace Officers. I understand I can receive injury leave for Peace Officers for one year, maximum. I understand that my sick and annual leave will continue to accrue during the period that I am receiving injury leave. I understand that I may be eligible for income benefits if injury leave is exhausted. Texas Code §661.918 allows this election ONLY to certain injuries of law enforcement officers that were injured in the line of duty for the Department of Public Safety, the Parks and Wildlife Dept., Alcoholic Beverage Commission, and the Attorney General.
Date to begin leave:_____Date to end leave:_____ (one year from beginning date)

MONTHLY TEMPORARY INCOME BENEFITS (TIB) ELECTION

☐ I elect to change my Temporary Income Benefits frequency from weekly to monthly. For more information about TIB, please visit the Texas Dept. of Insurance Website (https://www.tdi.state.tx.us/pubs/factsheets/tibs.pdf).

_____ _____ _____
Employee's Signature Date Coordinator's Signature

SORM-80 PO Rev. 06/2022

INSTRUCTIONS
Employee's Election Regarding
Utilization of Sick and Annual Leave—Peace Officers (SORM-80 PO)

Injured employees may elect to use accrued sick leave and all, part, or none of their accrued annual leave for time missed from work due to the work related injury. Accrued sick leave and accrued annual 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 annual leave.
- All sick leave must be exhausted before annual 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 annual leave before receiving workers' compensation income benefits.
- If you select 1B, you must use any sick leave balance and any authorized annual 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 who 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 as long as 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 of time.

If You Choose Election 2

- You choose to not use any sick or annual leave for your compensable injury. Your agency may immediately place you in a leave without pay 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 8th 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 or 75% of your weekly wage depending on your wages at the time of your injury.

If you Choose Election 4

- You have chosen to use injury leave for your injury. If your agency determines you are eligible, you may be entitled to one year of injury leave.

SORM
State Office of Risk Management

EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE

Employee's Name: _____ Date of Injury: _____

Employee's SSN: _____ Agency: _____

You are not required to use your leave. Texas Labor Code §501.044 allows an injured state employee to elect to use accrued sick and annual leave before receiving income benefits. NOTE: Sick leave must be exhausted before annual leave may be used. Other categories of leave (compensatory leave, holiday leave, administrative leave, etc.) may not be used prior to sick and annual leave.

Select only ONE election, either Election 1 or Election 2 below:

☐ **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 annual leave.

☐ B. A portion of my accrued annual leave (enter number below).

☐ C. None of my accrued annual leave.

If you selected B, how much of the portion of your leave do you wish to donate? _____

☐ **ELECTION 2**

When I lose time from work due to this injury or illness, I elect to not use any accrued sick leave or annual leave. I understand I am not entitled to workers' compensation income benefits until after the seven (7) calendar day waiting period.

If you know, please indicate how hours you have available: _____ Sick hours; _____ Annual hours

MONTHLY TEMPORARY INCOME BENEFITS (TIB) ELECTION

☐ I elect to change my Temporary Income Benefits frequency from weekly to monthly. For more information about TIB, please visit the Texas Dept. of Insurance Website (https://www.tdi.state.tx.us/pubs/factsheets/tibs.pdf)

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 the instructions on page 2.

Employee's Signature _____ Date _____ Coordinator's Signature _____ Date _____

SORM-808 Rev 03-16

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 annual leave for time missed from work due to the work related injury. Accrued sick leave and accrued annual 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 annual leave.
- All sick leave must be exhausted before annual 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 annual leave before receiving workers' compensation income benefits.
- If you select 1B, you must use any sick leave balance and any authorized annual 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 who 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 as long as 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 of time.

If You Choose Election 2

- You choose to not use any sick or annual lave for your compensable injury. Your agency may immediately place you in a leave without pay 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 8th 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 or 75% of your weekly wage depending on your wages at the time of your injury.

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.

Page 2

Witness Statement (SORM-74)

Download the SORM-74

Required:
Immediately after receiving notice of any injury, the claims coordinator should determine the names, addresses, and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to SORM.

Filing Deadline:
The form must be received by SORM not later than the **5th calendar day** after **the Employer's First Report of Injury or Illness (DWC-1S)** is filed with SORM.

Completed by:
The person giving the statement, with assistance from the claims coordinator.

Instructions:

1. Except for the witness signature, the witness statement form should be typewritten, if possible. If it must be handwritten, PLEASE PRINT to ensure legibility.
2. Be sure to fill in the claim number, if known.
3. The witness may have actually seen the accident, or may have acquired knowledge about the accident from some other source. The witness' information may relate to how the accident occurred or to something else that is relevant. Check the first or second box and fill in the blanks following those boxes, as is appropriate. Be specific and complete. Sometimes you will be given a witness name but who, when asked, denies any knowledge of the incident. In such a case the third box should be checked.
4. If the space provided on the form is insufficient, attach additional sheets. Please be as specific and complete as possible.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management Retain a copy for your file.

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code, the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.

SORM
State Office of Risk Management

WITNESS STATEMENT

MUST BE TYPED OR PRINTED

Injured Employee Name: _____ **Date of Injury:** _____

SORM Claim Number: _____ **Statement Taken By:** _____

Witness Name: _____

Witness Email Address: _____

Residence Address: _____

Primary Telephone: _____ **Secondary Telephone:** _____

Witness Employer: _____

On _____ **(date), at about** _____ **(time) in the** ☐ **a.m. /** ☐ **p.m., I was in or at** _____ **when an accident involving the above employee is reported to have occurred.**

SELECT CHOICE A, B, OR C BELOW:

Check only *one* box:

A. ☐ **I saw the incident.** The accident occurred in the following manner:

Other pertinent information and source:

B. ☐ **I did not see the incident.** Information given to me by (name of person):

Indicate how it occurred:

Other pertinent information and source:

C. ☐ **I know nothing whatsoever about the incident.**

_____ _____

Signature **Date**

SORM 74 rev 3/16

Supplemental Report of Injury (DWC-6)

Login to RMIS to complete the DWC-6

Required:
The DWC-6 should be completed immediately when the employee:

- Has returned to work;
- Has additional day(s) of disability;
- Has a change in weekly earnings after the injury (increase or decrease); or
- Is terminated or resigns.

Not Required:

- The DWC-6 should NOT be completed when the employee:
- Has reached MMI; or
- Has disability after termination or resignation.

Filing Deadline:
For each of the required situations listed above that the DWC-6 must be filed, the following are the corresponding filing deadlines:
Not later than the **3 days** after the employee returns to work;
Not later than the **3 days** after the additional day of disability occurs;
Not later than the **3 days** after the change in earnings has taken place; and Not later than the **3 days** after the employee resigns or is terminated.

Completed by:
The claims coordinator.

Instructions:

1. Check the appropriate boxes that show the reason for filing a Supplemental Report of Injury and complete only the blocks indicated.
2. In block 7 give **actual** wages. Please do not estimate wages.

Distribution:
Submit online to: State Office of Risk Management Mail a copy to the claimant.
Retain a copy for your file.

TDI Division of Workers' Compensation

CLAIM #
Carrier #

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
   ... If so, identify contact person and phone #
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date ____ no ☐
7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date ____ no ☐
9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
    ☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
    ☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
    ☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) xxx-xx-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy)
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
    If yes, the date of the 8th day (mm/dd/yyyy) ____
18. Date of most recent RTW ____
    ☐ Full duty, full pay
    ☐ Limited duty, full pay
    ☐ Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
    date of resignation ____ date of termination ____ date of death ____
    19a. Reason for resignation/termination
    19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐
20. Hours the injured worker was working during the pay period of ____ to ____ : ____ hours per week
    Indicated hours are:
    ☐ Increase from pre-injury
    ☐ Same as pre-injury
    ☐ Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of ____ to ____ : $ ____ weekly or $ ____
    Indicated wages are:
    ☐ Increase from pre-injury wage
    ☐ Same as pre-injury wage
    ☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.

Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

Signature and Title of person completing this form ____ Date ____

DWC FORM-6 (Rev. 10/05) Page 1 DIVISION OF WORKERS' COMPENSATION

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER)** are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.
This report must be filed in the following situations within the timeframes indicated: • 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury; • 3 days after the injured worker returns to work; • 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury; • 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury; • 10 days after the injured worker resigns or is terminated. **While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:** • If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time. • If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.	
This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: http://www.tdi.texas.gov/wc/rules

DWC-6 Violation Rule

DWC-6, Supplemental Report of injury
Texas Labor Code §409.005 and DWC Rule 120.3

The DWC-6 is required to be filed under a variety of conditions including: when an employee returns to work, when he/she experiences additional days of disability when there is a change in earnings, and when the employee is terminated or resigns. Other than the filings required for termination or resignation, the DWC-6 is required for every change in disability status; whether total or partial.

Often employees have returned to work at light duty with fluctuating wages or have intermittent periods of lost time (disability). It is important to understand that each change in disability status described above must be reported via a DWC-6 form. The purpose of these requirements is to ensure that the carrier has the information necessary to make adjustments to its payments of temporary income benefits so that the employee timely receives the compensation the employee is entitled to - no more, no less.

Failure to timely, accurately, and completely file a DWC-6 as required may be subject to a penalty not to exceed $25,000 per day of occurrence. Texas Labor Code §415.021.

Authorization for Release of Information (SORM-16)

Download the SORM-16

Required:
Immediately after sustaining a work-related injury, the claimant should fill out this release form. This enables SORM to obtain from providers copies of relevant medical documents that will assist in the handling of the claim.

Filing Deadline:
The form must be received by SORM not later than the **5th calendar day** after the **Employer's First Report of Injury or Illness (DWC-1S)** is filed with SORM.

Completed by:
The employee must complete this form. If the employee is incapacitated, the spouse, child, or legal guardian can sign the form. THE FORM MUST BE SIGNED AND DATED. The claims coordinator should make this form available.

Instructions:

1. The claimant must clearly print his or her name on the patient line.
2. The claimant must clearly print his or her name on the second line.
3. The claimant must date and sign the form.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management The claimant should retain a personal copy.

SORM
State Office of Risk Management

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:_____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management (SORM), and/or 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/or drug tests, X-rays, X- ray reports, including copies thereof) pertaining to the physical and/or mental condition which is the basis of my workers' compensation claim. This includes not only all current and/or 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)_____

SIGNED:_____ DATED:_____

Copies of this signed authorization will be considered just as valid as the original. This is not a release of claims for damages.

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU.

State Office of Risk Management
PO Box 13777
Austin, TX 78711-3777
(512) 475-1440
Fax: (512) 370-9025

SORM-16 Rev 3/16

Download the SORM-74

Required:
Immediately after receiving notice of any injury, the claims coordinator should determine the names, addresses, and telephone numbers of all witnesses to the incident. A statement should be taken from each witness and forwarded to SORM.

Filing Deadline:
The form must be received by SORM not later than the **5th calendar day** after the first notice of injury is reported to the agency.

Completed by:
The person giving the statement, with assistance from the claims coordinator.

Instructions:

1. Except for the witness' signature, the witness statement form should be typewritten, if possible. If it must be handwritten, PLEASE PRINT.
2. Be sure to fill in the claim number, if known.

SORM
State Office of Risk Management

WITNESS STATEMENT
Must be Typed or Printed

Injured Employee _____ SORM Claim Number _____

Date of Injury _____ Statement Taken By _____

Witness Name:_____ Witness email address:_____

Residence Address:_____

Primary Telephone:_____ Secondary Telephone:_____

Witness Employer:_____

On this date, _____, at about _____PM / AM I was in or at (clearly state your own location)

_____when an accident involving the above employee is reported to have occurred.

Check only one box

☐ **I saw the incident.**
The accident occurred in the following manner:

Other pertinent information and source:

☐ **I did not see the incident.** Information given to me by (name of person) _____
indicates that it occurred as follows:

Other pertinent information and source:

☐ I know nothing whatsoever about the occurrence.

_____ _____
Signature Date

Notification of Additional Information (SORM-90)

Login to RMIS to Complete the SORM-90

Required:
When an injured employee is granted extended sick leave, pooled sick leave or has child support payroll deductions, the employing agency must immediately notify SORM of that fact, by completing and submitting the SORM-90 form.

Filing Deadline:
The form must be received by SORM not later than **the next working day** after the change occurs.

Completed by:
The claims coordinator.

Instructions:
Be sure to fill in the claim number, if known.
All other blanks should be filled out as indicated or, if not applicable, mark N/A.
The claims coordinator should sign the form.
If child support is being deducted from the employee's payroll, include a copy of the child support order.

Please note: If the leave that is granted affects the state health contribution, an amended DWC-3 must also be filed.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management The claimant should retain a personal copy.

SORM
State Office of Risk Management

NOTIFICATION OF ADDITIONAL INFORMATION

Date: _____ Claim Number: _____ Date of Injury: _____

Employee Name: _____ SSN: _____

Child Support

- Employee has child support payroll deductions. Copy of Child Support Order attached.

Change in Information: Employee has had:

- Name change. New Name: _____
- Address change. New Address: _____
  _____
- Phone number/contact number change. New Number: (_____) _____
- Marital status change: _____
- Other Change: _____

Additional Leave Granted: Employee has been granted:

- Extended Sick Leave Hours: _____ Effective Date: _____
- Sick Leave Pool Hours: _____ Effective Date: _____
- Emergency Leave Hours: _____ Effective Date: _____

Leave Expiration Information

- The Employee's elected leave/additionally granted leave will expire on: _____ if he/she does not return to work.
- The Employee was granted Family Medical Leave Act (FMLA) on: _____

  This will extend the state paid portion of insurance through: _____
- The Employee's FMLA leave expired on: _____

  The first month the state will not pay insurance is: _____

Claims Coordinator: (Print) _____

(Sign) _____

Phone Number _____ Agency _____

Please fax this document to the State Office of Risk Management within 24 hours of the change.

SORM-90 Revised 1/23

NOTIFICATION OF ADDITIONAL INFORMATION

Purpose of Form: The SORM 90 provides a mechanism whereby the claims coordinator shall provide additional information to the adjuster pertaining to four elements of the claim.

- Child Support
- Change in Information
- Additional Leave Granted
- Leave Expiration Information

Filing Deadline: The form must be received by SORM not later than the next working day after the event/change occurs.

Completed by: The claims coordinator.

Instructions: Complete the identifying information at the top of the form

Child Support

If the claimant is having Child Support withdrawn from his/her paycheck, attach a copy of the order to the form. This is necessary so that the claimant receives the correct amount of income benefits.

Change in Information

Enter the revised data.

Additional Leave Granted

When an agency grants a claimant extended sick leave, sick leave pool hours, or emergency leave, the adjuster must factor in these additional hours with regard to initiation of income benefits.

Leave Expiration Information

This information is essential for ensuring that income benefits are paid timely and in the correct amount. Claimants often use intermittent leave for purposes other than their workers compensation injury and as a result, elected leave may not extend to the projected date of expiration.

Distribution: The claims coordinator will fax the document to the State Office of Risk Management and retain the original for the agency file.

SORM-90 Revised 1/23

Request for Travel Reimbursements (DWC-48)

Download the DWC-48

DWC Rule 134.110

When to file/provide to injured employee:
If the injured employee incurs travel costs for medical treatments or exams that are more than 30 miles one-way if there is no medical treatment reasonably available within 30 miles of their home location or for required medical exams more than 30 miles.

Filing Deadline:
The form must be filed with SORM within one year of when the travel costs were incurred.

Completed by:
The employee must complete this form. The claims coordinator should make this form available.

Instructions:

1. The claimant must clearly complete the form with applicable information.

Receipts for costs incurred must be attached and submitted with the form.

2. The claimant must date and sign the form.

Distribution:
Fax a copy or mail the original to: State Office of Risk Management Retain a copy for your file.

DWC048

TDI Division of Workers' Compensation

Complete if known:	
DWC Claim #	
Insurance Carrier Claim #	

Request to get reimbursed for travel costs

Este formulario está disponible en español en el sitio web de la División en
www.tdi.texas.gov/forms/dwc/dwc048trvlreims.pdf
Para obtener asistencia en español, llame a la División al 800-252-7031.

Filing instructions: Complete boxes 1-11 and sign the form. **Send it to the insurance carrier** within one year of when you incurred (charged) these costs. Keep a copy of the completed form and receipts. Do not send this form to the Division of Workers' Compensation (DWC).

Part 1: Information about injured employee, employer, and insurance carrier

1. Employee name (First, Middle, Last)	**2. Date of injury** (mm/dd/yyyy)
3. Employee mailing address (Street or PO Box, City, State, ZIP Code)	
4. Employer (at time of injury)	**5. Employee phone number**
6. Insurance carrier name	**7. Insurance carrier fax #**

Part 2: Information about travel

8. Trips for medical treatment and exams more than 30 miles one way.

Date	Travel from (street address)	Travel to (health care provider's name and street address)	Miles driven (round trip)

DWC048 Rev. 07/21

Page 1 of 3

DWC048

9. Overnight stays and meals. Send receipts for these costs.

Date	Location	Meals	Hotel/lodging
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$
		$	$

Part 3: Injured employee's statement

I certify the above information is correct and is for travel for treatment or an exam for my work-related injury.

10. Sign here: **11. Date:**

Part 4: Insurance carrier's response to injured employee's request to get reimbursed for travel costs

You must provide a plain language explanation of any partial payment or denial under 28 Texas Administrative Code (TAC) Section 134.110(f). Complete this section or use your own form and send a copy to the injured employee and the injured employee's representative, if any.

12. Response
Requested amount is:
- ☐ Approved
- ☐ Denied
- ☐ Partially Denied

13. Reason for denial:

14. Adjuster name: **15. License number:** **16. Date:**

Employer's Record of Injuries

Texas Labor Code §409.006, DWC Rule §120.1

An employer shall keep a record of all injuries and fatal injuries to employees as reported to an employer, or otherwise made known to an employer. The record shall include:
The name, address, date of birth, sex, wage, length of service, Social Security number, and occupation of the employee;
The reported cause of nature of the injury, the part of the body affected, and a description of any equipment involved;
The date, time, and location where the injury occurred;
The name of the employee's immediate supervisor;
The names of any witnesses (if known); and

1. The name and address of the treating health care provider, if known.

These records shall be available to the division at reasonable times and under conditions prescribed by the commissioner.

The employer shall retain a record of an injury until the expiration of five years from the last day of the year in which the injury occurred or the period of time required by Occupational Safety and Health Administration standards and regulations, whichever is greater.

Network Acknowledgement Form

[Download the Network Acknowledgement]

Employee Acknowledgement Form

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. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor.
2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The Employer Carrier will pay the treating doctor and other network providers.
4. 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)

I live at (Street Address)

(City) (State) (Zip Code)

Name of Employer