

Supervisor's Instructions and Responsibilities

Form to be completed by the supervisor:

1. SORM-703 (Incident/Accident Investigation Form)

Reporting an Injury:

When an employee reports an injury call the Workers' Compensation Coordinator in the Office of Human Resources, at 81-3555 immediately. The purpose for the immediate notification to the Workers' Compensation Coordinator is so that the coordinator can verify occurrences of an on-the-job injury to health care personnel who call as soon as the employee reaches the health care facility. If the coordinator has no knowledge of the injury, then the injured employee may be kept waiting for medical attention until the supervisor can be located and the injury verified.

Immediately complete the Supervisor's First Report of Injury or Illness and submit to Human Resources within 24 hours of notification. Injuries involving lost time that are submitted late are subject to monetary fines that will be charged back to the department. **DO NOT HOLD THE SORM-703 (Incident/Accident Investigation Form).** If the supervisor cannot fully complete the form, he/she should still forward it to the Office of Human Resources within 24 hours with a notation that further information is needed.

Employee Forms:

1. SORM-16 (Authorization for Release of Information)
2. SORM-80 (Employee's Election Regarding Utilization of Sick and Annual Leave)
3. SORM-29 (Employee's Report of Injury)
4. SORM-74 (Witness Statement) This form is for witnesses to complete if applicable.

Please provide the employee instructions and forms to the injured employee at the time of the injury.

Responsibilities Regarding Employees on Medical Leave

If an employee is on medical leave, the employee must keep the supervisor informed of absences and medical progress and submit all doctor statements. If, however, a supervisor does not hear from an employee whose off-work date has expired, it is a supervisory responsibility to contact the employee. If the employee cannot be reached and has not returned to work, please contact the Office of Human Resources at 81-3555.

Instructions for the Incident/Accident Investigation Form (SORM-703)

Purpose of Form: Effective loss control efforts require documentation of incidents and accidents to determine hazards or problem areas, procedures, or systems and to perform trending. Thorough investigation is required to determine the facts surrounding events so that remedial action can be taken, if required. The SORM 703 provides an outline of needed information. The document becomes a legal accounting of the facts surrounding the incident/accident.

Filing Deadline: If the incident or accident resulted in the filing of a workers' compensation claim, the form must be received by SORM not later than the **7th calendar day** after the filing of the TWCC 1s. Agencies having an established investigation procedure and form that meets or exceeds the requirements of the SORM 703 may, after review and approval by the SORM Risk Specialist assigned to the agency, continue to use the form. All other agencies must use this form.

Completed by: The Agency Accident Investigator (Supervisor)

A. Employee Data

Complete the top of the form with the identifying information and the date and time of the incident/accident. If a claim has been filed, complete the space for the claim number.

B. Incident Description

Attachment 1 contains benchmarked accident investigation procedures. Sufficient action is necessary to ensure that all facts surrounding the incident/accident are obtained so that effective loss control procedures can be established to protect against future incidents/accidents occurring. The form is developed to capture this information and to help the accident investigator come to reasonable conclusions concerning the events.

1. Where did the incident happen? – Go to the scene. Provide a visual image of the location of the incident. The reader should be able to visualize the area and the surrounding environment.
2. What was happening at the time of the incident? – Document the sequence of events leading up to the incident/accident. Include names of people interviewed and activities surrounding the event.
3. Describe any injury incurred, body parts and kind/s of injury/ies. – Through interview with the affected employee, determine what kinds of injuries were sustained and what body parts were involved.
4. What exactly caused the physical injury, or if an injury was avoided, what could have caused an injury? – What were the mechanics that caused the injury or could have caused an injury? Were procedures followed? Are the procedures faulty? Was equipment in good repair? Were there environmental hazards?

C. Investigation Results

5. After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/ injury?

D. Corrective Action

6. What is recommended to help prevent this type of incident/accident from occurring again? Provide short term and long term corrective actions that will prevent or eliminate the hazardous condition, unsafe work practice, and root causes
7. Who will be contacted concerning recommended action to ensure follow-up? Completion of this section ensures that the management staff involved knows that action has been taken to remedy the hazardous condition.

State Office of Risk Management
Incident/ Accident Investigation FORM 703

A. Employee Data			Claim # (if known):			
Date of incident:				Time:		A.M P.M.
Employee Name:						
Working Title:				Dept.		
Employee Contact #:	Hm.		Wk.		Other	
Supervisor Contact:					Wk	

B. Incident Description

Obtain written and/or recorded statements from injured employee. What happened? What caused the accident? What were the contributing factors? Reconstruct the sequence of events that led to the injury. Attach additional sheets if necessary. This document becomes a legal accounting of the facts surrounding the incident/accident. When documenting the facts, include answers to the following questions:

1. Where did the incident happen? Provide a full description of the surroundings of the location.
2. What was happening at the time of the incident? What were the events leading up to the incident?
3. What exactly caused the physical injury? What were the mechanics involved? Or, if a physical injury was avoided, what could have happened to cause an injury?
4. Describe any injury incurred by the employee, what body part/s and what kind/s of injury/ies. If there are no injuries, so state.

C. Incident Findings

After review of all facts, what was the hazardous condition, unsafe work practice or other root cause of the incident/ injury?

D. Corrective Action

What is recommended to prevent this type of incident/accident from occurring again?

Actions taken to ensure recommendations are considered:

Signature of Accident Investigator

Date

Time

For HR Management Use

Internal Distribution: Original: Agency Risk Manager or Risk Management Contact

Copies: Agency Safety Officer
Employee's Supervisor
Director/Manager of Department or Section

**Maintain one copy in any retrievable format in the site file for a minimum of 3 years,
or in the case of an occupational illness or injury, for 30 years.**

Note: If a workers' compensation claim is filed, send:

- Fax a copy to the State Office of Risk Management (SORM) Claims Department at 512-472-0237.

ACCIDENT INVESTIGATION BEST PRACTICES

I. Fact-Finding

1. Emphasis is placed on gathering facts; not to place blame, or determine the cause of accident.
2. Inspect the accident site before any changes occur.
3. Preserve essential and critical evidence.
4. Take photographs and/or make sketches of the accident scene.
5. Interview the injured employee and witnesses as soon as possible after an accident. Record pre-accident conditions, the accident sequence, and post-accident conditions.
6. Document the location of injured employee, witnesses, machinery, equipment, energy sources, and hazardous materials.
7. Ask *who, what, when, where, why, and how* during interviews.
8. Re-interview injured employee and witnesses to resolve conflicting accounts of the accident.
9. Remain completely objective during interviews and in documentation – no opinions, just the facts.
10. Keep complete and accurate notes.

II. Interviews

1. Get preliminary statements from victims and witnesses as soon as possible.
2. Explain the purpose of the investigation (accident prevention) and put each witness at ease.
3. Let each witness speak freely and take notes without distracting the witness.
4. Record the exact words used by the witness to describe each observation.
5. Be sure that the witness understands each question.
6. Identify the witness completely (name, occupation, years of experience, phone number).
7. Supply each witness with a copy of his or her statement (signed statements are desirable).

III. Accident Reconstruction

1. Develop a sequence of events from the information obtained from the victims and witnesses.
2. Identify hazardous conditions present during the accident.
3. Identify unsafe work practices present during the accident.
4. Identify system issues that caused or contributed to the accident.
5. Determine root causes of the accident by Fault Tree Analysis, Job Safety Analysis, or other methods.
6. If discrepancies exist, contact SORM claims adjuster regarding the discrepancies, and possibly seek assistance from professional accident investigator/reconstructionist.

IV. Investigation Reporting

1. Provide complete, thorough information about the accident (the *who, what, when, and where* data).
2. Describe the accident. Document the sequence of events of the accident. Identify the extent of damage to the employee and/or property.
3. Identify hazardous conditions and/or unsafe work practices for each event of the accident.
4. Identify the root cause of each hazardous condition or unsafe work practice.
5. Provide short-term and long-term corrective actions that prevent or eliminate the identified hazardous conditions, unsafe work practices, and root causes.
6. Describe the corrective actions recommended, the persons who are accountable for each corrective action, and the approximate time frame for correction.

V. Corrective Actions

1. Recommend immediate corrective actions to eliminate or reduce hazardous conditions and/or unsafe work practices.
2. Recommend long-term corrective actions that correct policies, programs, plans, processes, and/or procedures.
3. Recommend engineering controls, administrative controls, and/or personal protective equipment.
4. Estimate the cost to implement each immediate and long-term corrective action.
5. Develop an action plan for each corrective action.
6. Monitor implementation of the action plan to ensure appropriate corrective action is taken.

Employee's Instructions and Responsibilities

Forms to be completed by the employee:

1. SORM-16 (Authorization for Release of Information)
2. SORM-80 (Employee's Election Regarding Utilization of Sick and Annual Leave)
3. SORM-29 (Employee's Report of Injury)

Employees are responsible for reading and becoming familiar with the following information that outlines the injured employee's rights and responsibilities. If there are any questions please contact the Office of Human Resources at 81-3555.

Reporting an Injury

An employee should report an injury or job-related illness to the immediate supervisor within 24 hours of the incident. By law, the employee has up to 30 days from the date of the injury to report it; however, if the employee does not meet the 30 day deadline, the claim may be denied.

Responsibility of the Employee while on Medical Leave

It is the employee's responsibility to keep in weekly contact with the supervisor when the employee has been removed from work by a physician. The employee must submit a DWC-73 (Work Status Report) indicating the specific dates the employee is unable to return to work.

An employee may be placed on leave of absence without pay when available paid state leave is exhausted. If the maximum leave period expires and the employee has not returned to work, then the employee will be terminated.

Family Medical Leave Act (FMLA)

If the employee is removed from work by a physician, then the employee should apply for FMLA. If an employee is approved for FMLA the employee will be allowed to keep the state contribution for his/her health insurance and be restored to the same or equivalent position for up to 12 weeks. The FMLA policy and forms are located on the benefits website at the following link: http://www.twu.edu/humanresources/FMLAPolicy_324.htm.

Insurance While on Leave Without Pay

If an employee's insurance must be canceled for non-payment of premiums while the employee is on LWOP, insurance will be reinstated once the employee returns to work.

Returning to work

Employees are expected to report to work immediately at the beginning of their regularly assigned work shift upon release from a physician. The employee must bring the DWC-73 (Work Status Report) with them to submit to their supervisor when returning.

AUTHORIZATION FOR RELEASE OF INFORMATION (SORM-16)

Patient: _____

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management, 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) _____

Photostatic copies of this signed authorization will be considered as valid as the original.

This is not a release of claims for damages.

DATED: _____ SIGNED: _____

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

THANK YOU.

STATE OFFICE *of* RISK MANAGEMENT

Explanation of Election Choices (SORM-80)

Injured employees who lose time from work must elect whether to use their accrued sick leave and all, part, or none of their accrued annual leave for lost time due to their injury. Accrued sick leave and accrued annual leave are the amounts of leave available at the time of injury plus leave earned after the injury. The following details the effects of the different choices available to you:

If You Choose Election 1

- ★ Injured employees must use all their accrued sick leave and they may also use all, some, or none of their accrued annual leave.
- ★ All sick leave must be exhausted before annual leave can be used.
You must continue to use sick leave before receiving workers' compensation benefits, even if you have returned to work for a time, but are out again because of your injury. You may wish to consult with your Human Resources department to discuss the impact of this on your leave balances and insurance benefits, should you be off work for an extended period.
- ★ 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.

If You Choose Election 2

- ★ You have chosen to use no sick or annual leave for your compensable injury. This means that you will not receive any payment for the first seven (7) calendar days that you are off work due to your on-the-job injury, unless you are off work for at least 14 days
- ★ Workers' compensation benefits do not start until the eighth day of lost time. Employees who cannot work for 15 days will then receive retroactive benefits for that seven-day period.

Regardless of Which Choice You Make

- ★ Injured employees cannot receive workers' compensation payments while utilizing sick leave, sick leave pool, extended sick leave, or annual leave.
- ★ Injured employees cannot change their election after making any selection and signing the form.
- ★ If you do not send in a form, it is assumed that you have chosen to use NO sick or annual leave (Election 2).

**EMPLOYEE'S ELECTION REGARDING
UTILIZATION OF SICK AND ANNUAL LEAVE
(SORM-80)
(Texas Labor Code, Sec. 501.044)**

Employee's Name _____

Date of Injury _____

Complete Election 1 or Election 2.

ELECTION 1 *(must choose A, B, or C)*

Sick leave must be exhausted before annual leave can be used.

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 of hours: _____)*.
- C.** None of my accrued annual leave.

ELECTION 2

- When I lose time from work due to this injury or illness, I elect **not** to use any accrued sick leave and/or annual leave. I understand I will not receive workers' compensation payments until after the seven (7) calendar day waiting period.

I understand that I may not change my election after my eighth (8th) day of disability and signing this form.

I have read the reverse side of this form, and I fully understand the election I am choosing.

(Hours of Sick Leave)

(Hours of Annual Leave)

(Employee's Social Security Number)

(Name of Agency)

(Employee's Signature / Date)

(Claims Coordinator's Signature / Date)

CLAIM NUMBER _____
(If Known)

WITNESS STATEMENT (SORM-74)

**MUST BE TYPED
OR PRINTED**

Claimant _____
Employer _____
Date of Injury _____
Statement Taken By _____

Witness Name: _____ Age: _____
Residence Address: _____
Home Telephone: _____ Work Telephone: _____
Employer: _____
On _____, 20_____, at about _____ p.m./a.m., I was
in or at (clearly state your own location) _____

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

(check only one box)

I saw the accident.
The accident occurred in the following manner: _____

Other pertinent information and source: _____

I did not see the accident.
 Information given me by (name of person) _____
indicates it occurred as follows: _____

Other pertinent information and source: _____

I know nothing whatsoever about the occurrence.

Signature

Date

EMPLOYEE'S REPORT OF INJURY (SORM-29)

Dear Claimant:

We have 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: _____ LAST FIRST MI MAIDEN	Social Security: _____ Date of Injury: _____
Address: _____ City: _____ State: _____	Employer: _____ Job Title: _____ Wk Schedule: _____
1) What was the exact location of the accident (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 body parts were injured?	
5) To whom and at what time did you report you were injured? Date _____ Time _____ Name _____ Title _____	
6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____ Name _____ Phone: _____ Name: _____ Phone: _____	
7) Which doctor did you see first? Date _____ Name: _____ Address: _____ Phone: _____	
8) Has a doctor taken you off work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was the first day you missed work? _____
9) If the doctor took you off work, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, when do you think you will return to work? _____
10) Date of Last Appointment: _____	11) Have you lost any wages due to your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
12) Please list names and phone numbers of other doctors or treatment providers have you seen regarding your injury: Name: _____ Phone: _____ Name: _____ Phone: _____ Name: _____ Phone: _____	
13. Have you had previous workers compensation injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please enter dates of injuries and the body parts injured.	
By affixing my signature, I attest that all information on this form is accurate and true.	
Signature: _____	Date signed: _____

Notice: With few exceptions, an individual is entitled on request to be informed about the information that 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 the information about the individual that is incorrect.

EMPLOYEE'S REPORT OF INJURY
(SORM-29)

Purpose of Form:	The injured employee completes this form to provide SORM with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury. This will help to expedite benefits in a more timely manner.
Filing Deadline:	The form must be received by SORM no later than the 5th calendar day after the First Report of Injury or Illness (TWCC-1S) is reported to the agency.
Completed by:	The claimant with assistance from the claims coordinator, if needed.
Instructions:	<ol style="list-style-type: none">1. The claimant will address each of the questions completely and is to use additional pages if necessary. The adjuster needs a complete picture of the events surrounding the injury and how the injury occurred. Witnesses names and phone numbers, physician/Treatment Providers names and phone numbers and work status is needed. The claimant should enter any previous workers compensation claims and the body parts injured2. The Claimant will sign and date the form thereby attesting that all information on the form is accurate and true.
Distribution	The claims coordinator will fax the document to the State Office of Risk Management and retain the original for the agency file.