

## **INFORMATION FOR AN INJURED UNT HEALTH SCIENCE CENTER EMPLOYEE**

### **CONTENTS:**

Purpose Of This Packet	page 1
What Is Workers' Compensation?	page 1
Accident Reporting Procedures	page 2
What Benefits Are Paid?	page 2,3
Keep In Touch	page 4
Return To Work	page 4
Answers To Often Asked Questions	page 5

### **PURPOSE OF THIS PACKET:**

This packet gives you, the injured employee, important information about how to comply with the reporting requirements of the Workers' Compensation Commission, so the Human Resource Services Department, Payroll Office, Safety Office and the Workers' Compensation Division of the State Office of Risk Management can process your on-the-job injury claim. The timely completion of the required paperwork will help to minimize delays and confusion. This packet also provides you with basic information on the benefits available to you under the Workers' Compensation Act. Because each employee's financial situation is different, you should use the information in this packet only as a guide for your decision making. To answer any questions you may have, please call Jimmie Wilson, Claims Coordinator, Human Resource Services Department, at 817/735-2693.

### **WHAT IS WORKERS' COMPENSATION?**

The Workers' Compensation Law for Texas state employees went into effect establishing the State of Texas as a self insurer with all funding appropriated by the Legislature. Funds are made available for all reasonable and necessary medical services incurred as a result of work-related injuries/illnesses. The program is designed to help state employees meet **some** of their financial obligations while they are unable to work as a result of an on-the-job injury or illness. This program is not designed to pay an injured employee's full salary while he/she is unable to work.

There are two parts to the Workers' Compensation Program. One part covers certain medical expenses, the other part makes weekly compensation payments to injured employees who are unable to return to work while they recover from an on-the-job injury.

## **ACCIDENT REPORTING PROCEDURES:**

The employee has 30 days to report an injury. Upon notification of injury to the supervisor, the supervisor will complete the Employer's First Report of Injury or Illness (TWCC-1S) as well as the Supervisor's Investigation of Employee's Accident/Incident (Form June 2000). If the employee is expected to be off work, he/she will need to complete the Employee's Election Regarding Utilization of Sick and Annual Leave (SORM-80). The Witness Statement (SORM-74) should be completed immediately if there is a witness to the accident. The supervisor will forward all required forms to the Human Resource Services Department.

In order to be eligible for compensation for a work-related injury/illness, a TWCC-1S must be on file in the Human Resource Services Department.

## **WHAT BENEFITS ARE PAID?**

**An employee may choose his/her initial doctor. If an employee wants to change doctors the employee will need to call the State Office of Risk Management, 512/475-1440, for approval.**

- Medical Expenses - Injured employees are entitled to medical, hospital, nursing and chiropractic services, and such medicines as may be **reasonably necessary** at the time of injury, and any time thereafter for care and relief from the effects naturally resulting from the injury. The employee should make every attempt to ensure that attending physicians gain pre-approval for all testing, orthodic devices, and other major treatments from the State Office of Risk Management prior to their dispensing.

Oftentimes, the physician chooses to directly bill the State Office of Risk Management. He/she may forward reports and bills to the State Office of Risk Management, Wm. P. Clements Jr. Bldg., 6<sup>th</sup> Floor, P. O. Box 1377, Austin, Texas 78711. However, Human Resource Services should be kept informed of as many of these billings as possible (particularly if an initial report of injury indicates no need for treatment and the injured employee finds later that treatment is required).

Should the employee be billed by the physician, he/she should make copies for his/her records and send the original bills to the Human Resource Services Department along with his/her name, social security number, and workers' compensation claim number (if known). Human Resource Services will forward the bill to the State Office of Risk Management.

- Compensation Payments - If the employee's doctor has indicated that he/she will be absent from work, the employee must elect whether to use accrued sick leave and all or a part of accrued annual (vacation) leave before workers' compensation payments start. If the employee does not have accrued leave to cover the absence, that employee's paycheck will be reduced by the amount corresponding to the time not covered by the leave.

The Employee's Election Regarding Utilization of Sick and Annual Leave SORM-80 form includes two elections.

Election 1: Select this election to use all accrued sick leave and all, some or none of accrued annual (vacation) leave. All sick leave must be exhausted before annual (vacation) leave is used. The election is divided into three parts (A, B, and C). The employee must continue to use sick leave before receiving workers' compensation benefits, even if the employee returns to work for a time, but is off work later because of the injury.

- A. Use all of accrued sick leave and then all of accrued annual (vacation) leave.
- B. Use all of accrued sick leave and then a portion of accrued annual (vacation) leave.
- C. Use all of accrued sick leave and none of accrued annual (vacation) leave.

Election 2: Select this election to use none of accrued sick leave and none of accrued annual (vacation) leave. The employee will receive no payment for the first seven (7) calendar days while off work due to an on-the-job injury, unless the time off work is at least 28 days.

**Once a selection is made and the form is signed, you cannot change your election. If no election is made, you lose the option to use sick leave or annual leave in lieu of workers' compensation payments.**

You may be eligible for Family and Medical Leave during your absence from work. (Please call Jimmie Wilson at 817/735-2693 for information about Family and Medical Leave.)

Weekly compensation payments are calculated on the average weekly wage for the 13 weeks prior to the injury. The Compensation Act has set maximum and minimum payments established by statute. Please consult the claims coordinator in the Human Resource Services Department for the current maximum and minimum payments.

Employees who receive weekly workers' compensation payments will receive payments directly from the State Office of Risk Management, not the health science center. Processing of your claim from the time the Human Resource Services Department receives it through the State Office of Risk Management in Austin, Texas, takes approximately two to three weeks.

## **KEEP IN TOUCH!**

An injured employee **must** keep in touch with his/her supervisor. It is vital that you let your supervisor know how you are doing. If your injury will require you to be off for more than one week, you **must** contact your supervisor at least **weekly** until you return to work. Please also keep the Claims Coordinator informed of your absences.

## **HOW TO RETURN TO WORK:**

You must obtain a release to full duty from all physicians involved in your case prior to returning to work. The day you receive your full release to return to work, inform your supervisor. Bring these releases to your supervisor before you report back to work.

**If further absences are required as a result of your injury, you must notify the Claims Coordinator in the Human Resource Services Department immediately.**

Updated 02/2001

## ANSWERS TO OFTEN ASKED QUESTIONS

- Q. Are Worker's Compensation benefits taxable?** No.
- Q. Will I have more take home pay if I use Worker's Compensation instead of using my leave?** Maximum and minimum payments are established by statute, and are almost always less than your full regular wages.
- Q. Will the state continue to contribute to my insurance and retirement if I use Worker's Compensation?** If you worked during the month, yes.
- If you were off for an entire month and you used your accumulated leave to cover your absence, yes.
- If you were off an entire month and this time was not covered by accumulated leave, no. To continue your present insurance coverage during a month that you did not work, you will be billed for the total amount of premiums due (your usual monthly contribution plus the State's).
- Q. Will I be contacted by the State of Office Risk Management?** Yes, you will receive a claim number and may be asked to fill out additional forms.
- Q. What do I do with bills I receive as a result of my on-the-job injury?** If your bill(s) indicate(s) that your physician/clinic/hospital will file your claim directly with worker's compensation, you should retain your bills for your records.
- If your bill(s) indicate(s) or you have been told by physician/clinic/hospital that you must submit the bills to the State Office of Risk Management, make copies for your records and send the originals to the Human Resource Services Department along with your name, social security number, and your Worker's Compensation claim number if you have it. The Human Resource Services Department will forward your bills to the State Office of Risk Management.
- Q. What do I do if I come back to work after an injury and further absences are required as a result of the same injury?** You must contact the Human Resource Services Department immediately. You do not need to fill out another accident report form.
- Q. Will I continue to accumulate sick leave and vacation leave while I am receiving weekly Worker's Compensation benefits?** If you worked during the month, yes. If you were out for the entire month, no.
- Q. Will I be eligible to use Family and Medical Leave during my absence?** You should talk with someone in the Human Resource Services Department about eligibility requirements.

## **EMPLOYEE'S REPORT OF INJURY (SORM-29)**

**Required:**

This form should always be filled out by the injured employee and returned to the Claims Coordinator to be filed with the State Office of Risk Management (SORM). This will help to expedite benefits in a more-timely manner.

**Filing Deadline:**

The form must be filed with SORM no later than the third calendar day after the first notice of injury (TWCC-1S) is filed.

**Completed By:**

The claimant must complete this form. The Claims Coordinator can assist the employee in the completion of this form.

**Instructions:**

All questions must be answered and printed legibly. Be sure to sign and date the bottom of the form.

**EMPLOYEE'S REPORT OF INJURY**

Dear Claimant:

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

- 1. Name: \_\_\_\_\_ Social Security: \_\_\_\_\_  
LAST FIRST MI MAIDEN
- 2. Give your current home address: \_\_\_\_\_
- 3. By whom are you employed? \_\_\_\_\_
- 4. What is your job title/description? \_\_\_\_\_
- 5. What are your monthly wages? \_\_\_\_\_ 6. How many days per week do you work? \_\_\_\_\_
- 7. On what date were you injured? \_\_\_\_\_
- 8. What was the exact location of the accident (street address if possible)? \_\_\_\_\_  
 \_\_\_\_\_
- 9. How did the accident happen? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- 10. What part of your body was injured? \_\_\_\_\_
- 11. When did you report this accident? \_\_\_\_\_
- 12. To whom did you make your accident report? \_\_\_\_\_
- 13. List name(s), address(es), and telephone number(s) of witness or witnesses: \_\_\_\_\_  
 \_\_\_\_\_
- 14. Name, address, and telephone number of physician who provided treatment: \_\_\_\_\_  
 \_\_\_\_\_
- 15. When did you first receive treatment? \_\_\_\_\_
- 16. When did you stop working as a result of your accident? \_\_\_\_\_
- 17. Name, address, and telephone number of doctor presently treating you: \_\_\_\_\_
- 18. When were you last treated? \_\_\_\_\_
- 19. Have you returned to work? \_\_\_\_\_ If so, when? \_\_\_\_\_
- 20. Have you lost any wages on account of your accident? \_\_\_\_\_
- 21. Have you ever had a previous injury claim? \_\_\_\_\_ If so, describe: \_\_\_\_\_  
 \_\_\_\_\_

(dated) \_\_\_\_\_

(signed) \_\_\_\_\_

## **AUTHORIZATION FOR RELEASE OF INFORMATION (SORM-16)**

**Required:**

Immediately after sustaining a work-related injury, the claimant should fill in this release form so that the State Office of Risk Management (SORM) can obtain from providers copies of relevant medical documents which will assist in the handling of the claim.

**Filing Deadline:**

The form must be submitted to SORM no later than the third calendar day after the first notice of injury (TWCC-1S) is filed.

**Completed By:**

The claimant must complete this form.

**Instructions:**

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

# 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

## **EMPLOYEE'S ELECTION REGARDING UTILIZATION OF SICK AND ANNUAL LEAVE (SORM-80)**

**Required:**

The injured employee must choose whether or not to use sick leave and all or a portion of accrued annual leave before receiving workers' compensation income benefits.

**Filing Deadline:**

The form must be submitted to SORM no later than the third calendar day after the first day of lost time.

**Completed By:**

The form is completed by the injured employee with assistance from the Claims Coordinator.

**Instructions:**

1. If the employee chooses to use accrued sick leave and all accrued annual leave, the employee should mark "A" of Election 1.
2. If the employee chooses to use sick leave and a portion of accrued annual leave, the employee should mark "B" and enter the number of annual leave hours to be used.
3. If the employee chooses to use sick leave only and none of accrued annual leave, the employee should mark "C."
4. If the employee chooses not to use any accrued sick leave and/or annual leave, the employee should mark Election 2. The employee would be on a leave-without-pay status for any lost time due to this injury. Workers' compensation payments would begin after the seven-calendar-day waiting period. If the employee missed work for 28 days, workers' compensation benefits would be paid for the first seven days off due to the injury.

**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 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 my 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)

# 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 28 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 28 days
- ★ Workers' compensation benefits do not start until the eighth day of lost time. Employees who cannot work for 28 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).

## **WITNESS STATEMENT (SORM-74)**

**Required:**

Immediately after receiving notice of any injury, all witnesses should complete a written statement about the incident that caused the injury and forward the statement to the Claims Coordinator to forward to the State Office of Risk Management (SORM).

**Filing Deadline:**

The form must be submitted to SORM no later than the third calendar day after the first notice of injury (TWCC-1S) is reported to the employing agency.

**Completed By:**

The form is completed by the person giving the statement assisted by the Claims Coordinator.

**Instructions:**

1. Except for the witness' signature, the form should be printed legibly.
2. The information above the boxes should be completed.
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.
4. If the person has no knowledge about the incident, the third box should be marked and the form should be signed and dated.
5. If the space provided on the form is insufficient, attach additional sheets. Please be as specific as possible.

**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 \_\_\_\_\_, 19\_\_\_\_\_, 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 RIGHTS AND RESPONSIBILITIES UNDER THE TEXAS WORKERS' COMPENSATION SYSTEM

*This information describes your rights and responsibilities under the Texas workers' compensation system. For more information or for assistance, please call the Texas Workers' Compensation Commission field office handling your claim, or call 1-800-252-7031.*

### **Your rights under the Texas workers' compensation system**

#### **1. You may have the right to receive benefits.**

You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefits if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured by another person for personal reasons, you were injured while voluntarily participating in an off-work activity, you were injured by an act of God, or your injury occurred during horseplay.

#### **2. You have the right to receive the medical care reasonable and necessary to treat your work-related injury or illness the rest of your life.**

#### **3. You have the right to the initial choice of doctor.**

You may not change doctors except with the approval of the Commission. You do not need to get approval to go to a different doctor for emergency treatment, if you or your doctor moves, or if your doctor is unable to continue treating you.

#### **4. You have the right to hire an attorney to help you get benefits or to help you resolve disputes.**

#### **5. You have the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding, from a Commission ombudsman free of charge. To request assistance, contact the field office handling your claim, or call 1-800-252-7031.**

You have the right to receive information and assistance regarding your claim.

Commission staff will explain your rights and responsibilities under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Commission ombudsman in informal dispute resolutions and in administrative proceedings if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you.

## **6. You have the right to confidentiality.**

Only people who need to know—such as your doctor, your employer, or your employer's insurance carrier—may see information in the Commission's files. A prospective employer may get limited information from the Commission about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for them to do so.

## **YOUR RESPONSIBILITIES UNDER THE TEXAS WORKERS' COMPENSATION SYSTEM**

### **1. You have the responsibility to tell your employer about your injury or illness.**

You must tell your employer *within 30 days* of the date you were injured, or *within 30 days* of the date you first knew your illness might be work-related. You, or someone helping you, may either talk with or write your employer or any supervisor where you work.

*If you do not tell your employer within 30 days, you could lose your right to get benefits.*

### **2. You have the responsibility to fill out a claim form and send it to the Commission.**

You must send a completed claim form, called a TWCC41, to the Commission *within one year* of the date you were injured, or *within one year* of the date you first knew your illness might be work-related. Send the completed claim form to the Commission even if you are already getting benefits.

*If you do not send the form within one year, you could lose your right to get benefits.* For a copy of the form, call the field office handling your claim, or call 1-800-252-7031.

### **3. You have the responsibility to tell the Commission and the insurance carrier any time your income changes.**

If you are *not* getting benefits and you have changed employers since your injury, tell the Commission if your injury causes you to miss work or lose income. Call 1-800-252-7031.

*If you are* getting benefits and you have changed employers since your injury, tell the Commission and the insurance carrier paying your benefits if your income changes. Tell the Commission and the insurance carrier regardless of whether your income went up or down. If you have stopped working since your injury, tell the Commission and the insurance carrier if you start working again or if you have a job offer.

### **4. You have the responsibility to tell your doctor how you were injured and if you believe it may be work-related.**

If possible, tell the doctor before the doctor treats you.

5. You have the responsibility to tell the Commission and the insurance carrier how to contact you.

You should contact the Commission and the insurance carrier if your home address, work address, or phone number changes, so the Commission and the insurance carrier will be able to contact you when necessary.

***Employers: You must provide this information to the injured worker at the same time you report the injury to your insurance carrier. If your insurance carrier has agreed to provide this information to the worker for you, you still have the ultimate responsibility to ensure that the worker receives it. This information must be provided in English and Spanish or in English and the language common to the worker. This information may be reproduced or photocopied as necessary but may not be edited or altered in any way (7WCC Rule 120.2).***

## **DERECHOS Y RESPONSABILIDADES PARA EL TRABAJADOR BAJO EL SISTEMA TEJANO DE COMPENSACION PARA TRABAJADORES**

*Esta informacion describe sus derechos y sus responsabilidades en el sistema de compensacion para trabajadores en Tejas. Para mayor informacion o ayuda, por favor llame a la oficina local de la Comision Tejana de Compensacion para Trabajadores que maneja su reclamo o llame al 1-800-252-7031.*

### **Sus derechos en el sistema Tejano de compensacion para trabajadores**

#### **1. Usted puede tener derecho a recibir beneficios.**

Usted puede recibir beneficios a pesar de que alguien le causo o le ayudo a causar su lesion. Puede ser que no reciba beneficios si su lesion ocurrio mientras usted estaba intoxicado, si se lesiono intencionadamente o mientras estaba tratando de lastimar a otra persona ilegalmente, o si fue linado por otra persona por razones personales, si se lastimo mientras estaba participando voluntariamente en una actividad fuera del trabajo y despues de horas de trabajo, si fue lastimado por un acto de Dios, o si su lesion ocurrio mientras estaba payasando.

*Usted tiene el derecho de recibir tratamiento medico que sea razonable y necesario para tratar su lesion o enfermedad relacionada en su trabajo por el resto de su vida.*

**Usted tiene el derecho de escoger a su propio medico iniciadamente.**

**Usted no puede cambiar de medico, excepto con la aprobacion de la Comision. Usted no tiene que obtener aprobacion para ir a un medico diferente en casos de tratamiento de emergencia, o si usted o su medico se mudan o si su medico no esta disponible para continuar con su tratamiento.**

*Usted tiene derecho de contratar a un abogado para que le ayude a obtener beneficios o para que le ayude a resolver disputas.*

**Usted tiene derecho de recibir asistencia gratuita del personal apropiado y calificado de la Comision. En caso de que ocurra prediamento administrativo, tiene el derecho de recibir asistencia gratis de un ombudsman para resolver disputas. Para pedir ayuda, llame a la oficina local que esta manteniendo su reclamo o llame al 1-800-252-7031.**

**Usted tiene derecho de recibir informacion y asistencia racionada con su reclamo. Personal de la Comision le explicara sus derechos y responsabilidades bajo la Ley Tejana de Compensacion para Trabajadores. Adicionalmente, usted tiene el derecho de recibir asistencia de un ombudsman de la Comision en resolucion de disputas informales y en procedimientos administrativos si no tiene**

representacion legal. Sin embargo, un ombudsman no puede servirle como su representante legal o su abogado.

*Usted tiene el derecho a su confidencialidad.*

Solo personas que necesiten informacion acerca de su reclamo— como su medico, su patron cuando se lesiono, o la compania de seguros de ese patron—puede ver la informacion en el archivo de la Comision. Un futuro o posible patron puede obtener informacion limitada de la Comision acerca de sus reclamos. Si usted desea que alguien que lo este representando o asistiendo tenga acceso a su archivo, necesita primero proporcionar aprobacion por escrito antes de que lo puedan obtener. Sus responsabilidades dentro de el sistema Tejano de compensacion para trabajadores.

*Usted tiene la responsabilidad de notificar a su patron de su lesion o enfermedad.*

Usted debe notificar a su patron *dentro de 30 dias* desde la fecha que se lesiono, o *dentro de 30 dias* desde de la fecha en que usted se entrego primero que su lesion o enfermedad pudo haber sido relacionada con su trabajo. Usted, o la persona que le este ayudando puede hablar con o escribir al patron o a cualquier supervisor donde usted este trabajando.

*Si usted no notifica a su patron dentro de 30 dias desde la fecha de su lesion puede perder su derecho a beneficios.*

Usted tiene la responsabilidad de llenar un formulario de reclamo y enviarlo a la Comision.

Usted debe completar y enviar su formulario de reclamo, que se llama TWCC41, a la Comision *dentro de un ano* de la fecha en que se entrego que su lesion o enfermedad pudo haber sido relacionada con su trabajo.

Envie el formulario a la Comision a un que este recibiendo beneficios.

*Si usted no envia el formulario dentro de un año usted puede perder el derecho de recibir beneficios.*

Para obtener una copia del formulario, llame a la oficina local que esta manejando su reclamo o llame al 1-800 252-7031.

*Usted tiene la responsabilidad de notificar a la Comision y a la oficina de seguros cuando vea que cambien sus ingresos.*

Si usted *no* esta recibiendo beneficios y ha cambiado de trabajo desde su lesion, avise a la Comision si su lesion le causa faltar al trabajo o perder sueldo. Llame al 1-800-252-7031.

*Si usted esta recibiendo* beneficios y ha cambiado de trabajo desde su lesion, avise a la Comision y la compania de seguros que le esta pagando sus beneficios si hay un cambio de ingresos. Avise a la Comision o la compania de seguros a pesar de que suban o bajen sus ingresos. Si usted ha dejado de trabajar desde el dia de su lesion, avise a la Comision y la compania de seguros si empieza a trabajar de nuevo o tiene oferta de empleo.

*Usted tiene la responsabilidad de avisar a su medico como se lesiono y si cree que su lesion puede ser relacionada a su trabajo.*

**Si es posible, avise a su medico antes de que le de tratamiento medico.**

*Usted tiene la responsabilidad de avisar a la Comision y a la ceompania de seguros como se pueden comunicar con usted.*

**Debe de avisar a la Comision y la compania de seguros de cualquier cambio de domicilio, direccion de trabajo, o si cambio su numero de telefono, para que la Comision y la compania de seguros puedan comunicarse con usted cuando sea necesario.**

*Emprasario/Empleador: Usted debe proveer esta informacion al trabajador lesionado al mismo tiernpo que debe reportar el accidente o lesion a su compania de seguros. Si su compania de seguros esta de acuerdo en proveer esta informacion al trabajador de todas maneras usted tiene la responsabilidad de asegurar que el trabajador reciba esta informacion. Esta inforrnacion debe proveerse en ingles y en espanol o en el idiorna que sea comun al trabajador. Esta informacion pued e ser reproducida o fotocopiada tanto como se necesite. Pero no debe ser editado o alterado en ninguna forma. (Reglamento 120.2 de 7WCC).*