Risk Management/Insurance Department
Office: (432) 498-4011
Fax: (432) 498-4097

Payroll/Retirement Department
Office: (432) 498-4026
Fax: (432) 498-4097

ECTOR COUNTY, TEXAS
HUMAN RESOURCES DEPARTMENT

Dear Ector County Employee:

If you have an on-the-job injury or illness, you must complete the attached forms and return to Delia Ortiz in Human Resources as soon as possible.

1. Authorization for Release of Medical Records and
2. Employee Acknowledgment of receipt of Alliance Provider list

PLEASE KEEP THE FOLLOWING: myMatrixx WC Prescription Information sheet, Texas Workers' Compensation Commission Employee Rights and Responsibilities form, and the Alliance Provider list.

Ector County has chosen Alliance to manage the health care and treatment you may receive if you are injured at work. The Alliance includes a panel of health care providers who are trained in treating work-related injuries. A list of approved Workers' Compensation doctors is included in this packet. If you obtain health care from a doctor who is NOT on the list of Alliance doctors, without prior approval, you will be responsible for the cost of that care. For an updated list please go to www.pswca.org. It is updated weekly and identifies providers who are taking new patients.

If you are now unable to work because of this injury or illness, it is important that **I be notified** when you return to work. If you are now working, but as a result of this injury or illness, you have to miss work, it is also important that **I be notified** immediately. The insurance carrier will initiate Compensation on the eight calendar day of lost time. If you do not have any accrued time available, you will have to take time off without pay.

You also need to submit a written statement describing when, what, and where accident/incident occurred, as well as a list of witnesses. Please explain in detail what the injury/illness is as well as what part of the body was injured.

NOTE: An employee injured on the job MAY NOT see the doctor at the Ector County Employee's Care Here Wellness Center and may not use the health insurance prescription card for a work related injury.

Please call me at 432-498-4011 if you have any questions or need additional information.

Thank you,

Delia Ortiz

Delia Ortiz
Ector County, Benefits Coordinator
432-498-4011
Delia.ortiz@ectorcountytx.gov

RETURN THE FOLLOWING 3 FORMS TO HUMAN RESOURCES

1. EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

2. AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

3. EMPLOYEE ACKNOWLEDGEMENT OF PSWCA (ALLIANCE PROVIDER FORM)

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

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

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

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

40. Name and Title of Person Completing Form	41. Name of Business
Delia Ortiz	Ector County
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone 1010 E 8th Street, Room 126 (432) 498-4011	43. Business Location (If different from mailing address) Number and Street 1010 E 8th Street, Rm 126
City State Zip Code Odessa TX 79761	City State Zip Code Odessa TX 79761

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
75-6000934		921190	
48. Workers' Compensation Insurance Company		49. Policy Number	
Texas Association of Counties Risk Management		CRL-TXWC-010117	

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

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

TEXAS ASSOCIATION *of* COUNTIES

Workers' Compensation
Self-Insurance Fund

Date: _____

Employee Name: _____

Address: _____

Re-Claimant: _____ Claim Number: _____ DOI: _____

SS#: _____

Employer: Texas Association of Counties WCSIF Pool! **Ector County**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To Whom it May Concern:

I, _____ hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company or Government Agency to disclose or furnish to **JI Specialty Services, Inc.**, its subsidiaries or representatives, any and all information with respect to any illness including mental illness, drug/alcohol abuse, injury, medical history consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to **JI Specialty Services, Inc.** and/or its representatives, is to be used solely for the administration of claim(s). A photo static copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim.

_____ _____

Date Signature

NOTE: A true copy of this authorization is available to the employee at any time upon request.

Please attach to Incident report when filing with carrier. If sending separate please note social security of injured worker.

Family/ Dr Name: _____
Address: _____
City and State: _____ Zip: _____

Nancy Pickett-800-752-6301/(F)-512-346-9321/ email: nancy.pickett@jicompanies.com
PO Box 160120, Austin Texas 78716

TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

Employee Acknowledgment of PSWCA Direct Contacting Program

I have received information that informs me of my employer's relationship with the Alliance and how to get health care if I suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of doctors provided by my employer or obtain the list myself which is located at http://www.pswca.org/
2. I must for 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. JI Specialty Services on behalf of the Texas Association of Counties Risk Management Pool will pay the treating doctor and other referral providers.
4. I may be required to pay for health care received from a provider if that provider is NOT on the approved list.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
6. Additional information regarding the PSWCA is available on the pool's website at www.county.org.

_____ _____
Signature Date

_____
Printed Name

I live at: _____
Street Address

_____
City, State, Zip Code

Name of Employer: Ector County

Call 800-752-6301 if you need assistance locating a treating provider.

Please indicate whether this is the:

☐ Initial Employee Notification
☐ Injury Notification (Date of Injury: __/__/__)

Please return this form to Ector County Human Resources Department.