CITY OF BURLESON
EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS ACKNOWLEDGEMENT

Report to be completed and forwarded to the Human Resources Office within 24 hours of the accident.
By signing this form I agree that all of the information listed on the first report of injury is true and accurate.

Did Employee seek medical attention, if yes, please select from list below.

Did not go to doctor ☐ Huguley ER ☐

Concentra ☐ CARENOW ☑

Texas Health ER ☐

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

PLEASE NOTE:

THE SUPERVISORS SIGNATURE IS REQUIRED ON THIS FORM.

SUPERVISORS PLEASE DO NOT SIGN THE EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS FORM (THE FORM WITH ALL THE EMPLOYEES INJURY INFORMATION ON IT).

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 ☐	15. 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? YES ☐ NO ☐	If No, Specify Language		20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, 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	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City	State	Zip Code
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name CareNow			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box) 1501 SW Wilshire Blvd			26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name
City	State	Zip Code			29. Date Reported (m-d-y) - -
Burleson	TX	76028			

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: Deidre Hall, Benefits Manager		41. Name of Business: City of Burleson	
42. Business Mailing Address and Telephone Number Street or P.O. Box: 141 W. Renfro ST	Telephone: (817) 426-9642	43. Business Location (If different from mailing address) Number and Street	
City: Burleson	State: TX Zip Code: 76028	City	State Zip Code
44. Federal Tax Identification Number: 75-6000475	45. Primary North American Industry Classification System Code:(6 digit) 921140	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.: 075-6000475
48. Workers' Compensation Insurance Company: Texas Municipal League IRP		49. Policy Number: A03511	

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 HR ONLY - DO NOT SIGN WHEN PRINTED - HR ONLY - DO NOT SIGN WHEN PRINTED Date

WORKER'S COMP AGREEMENT
FOR INJURED EMPLOYEE

This form is to be completed by employee at the time of injury. Turn in to HR with your First Report of Injury Form.

Please initial each item below:

_____ Copy of Worker's Comp Policy received.

_____ After being seen by the Worker's Comp doctor and you are given limited restrictions and the City of Burleson can accommodate the restrictions. The City of Burleson extends to you a bona fide offer of employment. Please be aware if you do not accept the offer, TML may decline to pay your lost time. Your initials indicate you understand you not be paid for lost time.

_____ Employee is required to check in weekly with supervisor if you are taken off work by Worker's Comp.

_____ A second opinion is an option during treatment. If you desire a second medical opinion, it is your responsibility to contact Texas Municipal League (TML), the City's workers' compensation insurance carrier. You will be required to see a physician within the workers' compensation network (Political Subdivision Workers' Compensation Alliance; www.pswca.org)

Salary Continuation: This section applies ONLY if the employee's injury is of a serious nature requiring them to miss substantial work hours. The decision regarding compensation for missed time is made by the City's insurance carrier, The Texas Municipal League, after consultation with the treating physician. City staff do not make this decision.

_____ The undersigned, having suffered an on-the-job injury while employed by the City of Burleson, Texas, and having read and understood Appendix A, of the City of Burleson Employee & Safety Policy Manual relating to payroll continuation, does hereby acknowledge that he/she shall continue to receive full salary for a period of sixty calendar days from the date of injury. In exchange for this benefit, the undersigned does hereby agree to endorse over to the City of Burleson, Texas any and all Worker's compensation payments (excluding medical reimbursement)

_____ During Salary Continuation. Employees must turn in endorsed Worker's Comp checks from TML to HR.

_____This is a voluntary agreement for the benefit of the employee, with it being specifically understood that breaching this agreement by inadvertently cashing a check you will be required to repay the City and future disciplinary action will be warranted which could result in termination of employment with the City of Burleson.

_____ _____
Employee Name Date of Injury

_____ _____
Employee Signature Date

Appendix A: Work Related Injury or Illness

A.1 Injury on the Job:

(a) Medical Care. The supervisor is responsible for ensuring that an employee who is injured during the course of employment receives appropriate initial medical care. When notified that an employee has been injured, a supervisor shall:

(1) Assure that first aid is given, if qualified personnel are available.

(2) Call for emergency medical assistance, if the injury is serious, as may be indicated by, but not limited to, profuse bleeding, broken bones, unconsciousness, or shock; or

(3) Transport the employee to the emergency care facility designated by human resources or an approved physician, if the injury requires medical care but does not warrant emergency transport.

(b) Reports. Regardless of the severity of the injury, an employee who is able must report immediately to the supervisor any injury incurred in the course of employment with the city. The immediate supervisor is responsible for filing the following reports with the human resources department for inclusion in the employee's personnel file:

(1) Employee's First Report of Injury or Illness: must be filed within 72 hours of the occurrence of injuries resulting in medical treatment or lost time;

(2) Supervisor investigation report: an incident report to be filed within 72 hours of the occurrence of an injury, regardless of severity.

(c) Physical Exam; Fitness for Duty

An employee who has been injured at work shall obtain a physical examination from an approved physician if the employee has received emergency treatment at a hospital; or) the department director has reason to believe that the physical condition of the employee could result in danger to persons or property or that it interferes with normal work performance, and the department director instructs the employee to report for examination.

(d) Employees who receive treatment (non-emergency) from a doctor are required to seek care from a physician that is approved through the City's workers' compensation insurance carrier, Texas Municipal League (TML). TML has formed an "Alliance" with numerous area doctors, and employees are to see one of the designated doctors in the Alliance. If a specialist is needed, the employee will be referred through the Alliance physician. More information is available in Human Resources, and employees will work with department management and Human Resources and the TML carrier to follow required protocols.

(e) Physician's release. If an employee receives treatment from a clinic or doctor the employee must obtain a written release from the attending physician or the city-designated physician, indicating the employee's fitness to return to duty. The release must stipulate what kind of duty is permitted, specify limitations, if any, and state the date of the employee's release from medical care.

(f) Physician Determination. If the physician determines that an employee is not able to perform all of the duties of the employee's position, as set forth in the job description, the physician will document the limitations.

(g) Modified Duty.

(1) Purpose. The purpose of this section is to provide a process by which employees injured at work may receive temporary work assignments that will benefit their full recovery. It is not intended nor to be used as a disability program.

(2) Evaluation of injured or ill employee. When an employee is required to be absent from work because of an extended period of recovery from injury or illness, the employee's case will be reviewed by the department director and the director of human resources. An examination and evaluation conducted by the attending physician or the city-designated physician will be used to determine the capabilities and prognosis for recovery of the injured or ill employee. A review of the potential work assignments will be conducted by the employee's director and the director of human resources to determine if an assignment is available which matches the injured or ill employee's training, skills and capabilities, as determined by the physician.

(3) Work assignment. A modified duty work assignment will be offered to an injured or ill employee if:

(A) a modified duty work assignment would enhance the recovery of an injured or ill employee and facilitate the employee's return to the regular duty work assignment held before the injury or illness; and

(B) the employee's department director determines that modified duty is available. If no modified duty can be found within the department, the employee may be temporarily assigned to work in another department, if there is an existing opening for which the employee is qualified and that meets the employee's work restrictions. A temporary assignment does not constitute the creation of regular or long-term employment in the assigned position. The salary of an employee on modified duty will be paid by the employee's department and the employee will be returned to the original position and department when released for full duty. If modified duty cannot be found, the city will not create a position and the employee will remain on leave.

(4) Length of modified duty work assignments. A modified duty work assignment may last until the time that the attending physician or city physician has set as the expected date of return to the employee's previous work assignment or until temporary work duties are completed, but not to exceed three months unless the city manager gives written approval for a longer period.

(5) Conditions of modified duty. As a condition of continuing in a modified duty work assignment, an employee must:

(A) adhere to prescribed treatment and make reasonable efforts toward rehabilitation;
(B) accept progressively more demanding assignments as the employee's condition improves; and
(C) make visible progress in returning to full performance capability.

(6) Termination of modified duty. An employee's modified duty work assignment will be terminated if:
(A) the employee is found performing beyond the modified duty restrictions;
(B) the work assignment is completed;
(C) the employee performs unsatisfactorily in the position;
(D) budgetary constraints do not allow continuation of the position; or
(E) the employee's medical condition worsens.

(7) Reassignments. If an employee's injury or illness will permanently prevent the employee from performing the essential functions of the employee's regularly assigned duties, the director of human resources in conjunction with the employee's director shall attempt to locate a suitable city position for the employee. Such position must be authorized and vacant and the individual must be qualified to perform the essential functions of the position. If no position is available at the time the individual is determined physically unable to perform the essential function of the employee's job, or, should the employee refuse to accept an available position, then termination of employment will occur. The city will not create a position.

A.2 Wages During Work Related Injury Leave (revised 01/01/2013)

(a) Eligibility. A full-time employee, injured in the course of employment with the city is eligible for injury leave for 60 calendar days during the period of time the employee is unable to work due to the injury.

(1) The Texas Workers' Compensation Commission will approve the workers' compensation insurance carrier to pay wages only for serious injuries. In general, a serious injury is one that a physician documents the employee

is unable to work for more than eight calendar days. The City of Burleson relies on the physician to determine any physical work restrictions and when the employee can return to a full-duty status.

(2) It is the responsibility of the designated supervisor or timekeeper to code all timesheet records appropriately during missed time.

(3) The City of Burleson pays the injured employee's wages as a benefit on the day of injury and the first eight calendar days, if the above conditions apply.

(4) If the employee is approved to receive wages from the Texas Worker's Compensation Commission, the salary continuation benefit (see A.2, b, below) may apply, if the employee is unable to work after the eighth calendar day.

(b) Salary Continuation Benefit. An employee who takes injury leave receives the following benefits:

(1) The employee continues to receive the employee's current rate of pay, exclusive of overtime, for not to exceed the number of work periods in 60 calendar days. In exchange for salary continuation, the employee must endorse the employee's workers compensation wage benefits over to the city. During the salary continuation benefit period, employees will be paid via paper check. It is the responsibility of the employee to turn in state issued workers' compensation wage to the Finance department and receive the city-issued wage check. If an employee is unable to come to the department due to injury, alternative arrangements will be made via the Human Resources department to assure the wages are exchanged.

(2) If at any time the employee abuses the privileges related to the salary continuation benefit, his/her employment may be terminated immediately.

(3) At the end of 60 calendar days, the employee may elect to supplement workers' compensation wage benefits by using accrued vacation, compensatory leave, or sick leave to make up the difference between workers compensation payments and the employee's full rate of pay.

(4) After all accrued leave has been exhausted the employee shall receive only workers compensation benefits as authorized by state law.

(c) Responsibility. An employee on injury leave is responsible for contacting the employee's supervisor, either in person or by phone, at least once every workweek.

(d) Benefits and Accrual. An employee on injury leave is not eligible for merit raises or promotions. However, during the first 60 calendar days of injury leave, the

employee will continue to accrue vacation and sick leave at the normal level. After 60 days, the accrual will continue only as long as the employee is using other available leave. When all available leave is exhausted, the employee will cease accruing vacation and sick leave until the employee returns to work.

(e) Return to work. Before an employee returns from injury leave or Family Medical Leave (FML), the employee must present a written release to work to the director of human resources from the employee's treating physician.

A.3 Life-Threatening Illness & Injury:

(a) Fair and equal treatment. Pursuant to its commitment to providing fair and equal opportunity to all employees while providing a safe work environment, the city will treat employees with life-threatening illness like other employees as long as they meet performance standards, are able to perform the essential functions of their position, and medical and other information indicates that their condition is not a threat to themselves or to others. The city will attempt to reasonably accommodate these employees whenever practical.

(b) Confidentiality and sensitivity. If an employee contracts a life-threatening illness, or if an employee discovers a fellow worker has contracted a life-threatening illness, all reasonable efforts should be exercised to ensure that this information remains private and confidential. All employees should treat employees with a life-threatening illness with compassion and understanding.

(c) Physical examination. To assure the city that an employee with a life-threatening illness is not a danger to anyone, the city may require the employee to be examined by a physician. All information related to the examination will be confidential and will be disclosed to the department director and/or supervisor only when necessary.

Notes: