

**Texas Department of Criminal Justice
Supervisor's Report Packet for Workers' Compensation**

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Texas Department of Criminal Justice Supervisor's Guidelines for Workers' Compensation

- ◆ **Maintain an ample supply of Employee's and Supervisor's Report Packets.**
- ◆ **If an employee was involved in a work-related incident which could have exposed them to a communicable disease such as Hepatitis B, HIV, or tuberculosis, immediately: (1) have the employee complete an "Employee's Report Packet for Workers' Compensation" and a PERS-305, "Possible Work-Related Exposure Form" (Attachment C to PD-45); and (2) send the employee to the CID nurse for possible testing. If the employee refuses to go for possible testing, have the employee sign a "Refusal to File a Workers' Compensation Claim" form that reflects that decision.**
- ◆ **Distribute an "Employee's Report Packet" and an applicable Position Description to any employee who sustains a work-related injury/illness. You may obtain the Position Description from the Human Resources Representative. Employees must complete and submit their packets to you during the same shift the injury/illness occurs.**

Ensure the employee reviews the "Employee's Report Packet for Workers' Compensation", understands the impact the C-80 election form will have on the employee's monthly paycheck and other benefits before you sign Part B of the "Notice of Employee's Work-Related Injury/Illness".

If the work-related injury/illness has rendered the employee unable to complete the packet and the employee did not designate someone to act on the employee's behalf, you must act as the designee, complete the employee's packet, and submit it to the Human Resources Representative during the same shift the injury/illness occurs. If you must complete the packet yourself, it then becomes your responsibility to follow up with the employee or the employee's designee within the next 24 hours to gather any previously unknown information and to inform them of the C-80 form choices and their effect. Report any information you discover to the Human Resources Representative immediately.

If the employee refuses to file a workers' compensation claim, instruct the employee to: (a) sign a statement that indicates that the employee does not want to file a workers' compensation claim for the work-related injury/illness (a sample of such a statement may be obtained from the Human Resources Representative); and (b) complete Part A of the PERS 298-2, "Notice of Employee's Work-Related Injury/Illness". Provide the "Refusal to File a Workers' Compensation Claim" form along with the PERS 298-2 form to the Human Resources Representative for maintenance in the employee's unit/department medical file. If at a later date the employee wants to file a workers' compensation claim, follow the instructions for an employee filing a workers' compensation claim.

- ◆ **Remove the DWC FORM-48, "Request for Travel Reimbursement" Notification and provide the Notification to the employee for possible future use.**
- ◆ **Audit Employee's Packet for the following:**

NOTE: Do not delay emergency medical treatment pending completion of packets!

PERS 298-2 "Notice of Employee's Work-Related Injury/Illness"

- Form is submitted during the same shift the incident occurred.
- Each section in Part A is completed
- Employee signed and dated the form

PERS 298-3 "Employee's Sick Time and Other Time Elections" (C-80 Form)

- Employee has chosen an election in each part, A and B, and signed and dated the form

PERS 298-4 "Authorization for Release of Information" (WCD-16 Form)

- Form is completed, signed, and dated

- ◆ **Coordinate with the Human Resources Representative to determine whether or not the employee is qualified for FML and follow guidelines in the appropriate policy.**

◆ **Complete the Supervisor's Packet during the same shift the injury/illness occurs.**

The Human Resources Representative should be able to answer any questions you may have about completing any form in the packet. The following information may help you complete the forms.

PERS 298-2 “Notice of Employee's Work-Related Injury/Illness”

Complete Part B, “Supervisor's Acknowledgement”. Coordinate with the Human Resources Representative to ensure that the Sick Leave balance on the date of injury (DOI) is correctly calculated by taking into consideration any sick time used since the last update to the time screen.

PERS 299-2 “Witness Statement”

You must obtain a witness statement from each witness the employee indicated. If the employee listed an inmate as a witness, the inmate's TDCJ identification number must be noted on the PERS 298-2, “Notice of Employee's Work-Related Injury/Illness” form.

NOTE: Do not delay in submitting report packets to the Human Resources Representative because you have not received applicable witness statements. Submit the packet without them and follow up on the statements later.

◆ **Submit the Employee and Supervisor packets to the Human Resources Representative.**

Submit your packet along with the Employee's Packet to the Human Resources Representative during the same shift the injury/illness occurs.

- You are not relieved of reporting responsibility even if the employee fails to furnish a completed Employee's Packet.

Verify the completeness of the Employee Packet and the Supervisor Packet by comparing each form with those listed on the Contents page of each packet (the top page of each packet).

◆ **If the employee has not notified the Human Resources Representative of the employee's change in status, submit a PERS 299-3, “Supplemental Worksheet” to the Human Resources Representative during the same shift of occurrence that the employee:**

- Returns to full duty after being absent due to the work-related injury/illness; (Prior to performing job duties, the employee must submit a DWC FORM-73, "Texas Workers' Compensation Work Status Report" or a health care provider's statement releasing the employee to full duty without restrictions if the employee was absent for more than three days, was on LWOP status, or the employee is returning to work after the employee's initial visit to the health care provider.)
- Requires additional days off due to the initial work-related injury/illness;
NOTE: The date is the first full shift of lost time after the employee's latest return to work
- Is called to service in the Uniformed Services while on leave without pay;
- Resigns or is separated from employment; or
- Dies.

NOTE: You are responsible for notifying the Human Resources Representative by the end of the shift of any changes to the employee's status which occur after the initial submission of the Supplemental Worksheet.

- ◆ **Maintain regular, weekly communications with the employee during the employee's recuperation from the work related injury/illness. The purposes of these communications are to:**
 - Encourage the employee during recuperation;
 - Communicate the value of the employee to the Agency; and
 - Encourage the employee's return to work at the earliest possible date.
- ◆ **Coordinate with the Human Resources Representative to ensure employee leaves are managed in accordance with applicable Agency policies and to ensure qualified absences are appropriately designated as FML.**

Texas Department of Criminal Justice
Witness Statement
(must be printed or typed)

Injured Employee's Full Name: _____ Date of Injury: _____

INMATES – COMPLETE THIS SECTION			
Name: _____		Age: _____	
Last Name	First Name	MI	
Unit/Location: _____		Inmate Identification Number: _____	

ALL OTHER WITNESSES – COMPLETE THIS SECTION			
Name: _____		Age: _____	
Last Name	First Name	MI	
Address: _____			
Street Address	City	State	Zip Code
Soc. Sec. No.: _____		Home Phone: () _____	Work Phone: () _____
I am an employee of: _____ Unit/Department.			
<small>Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the agency collects about you; and (2) under Sections 552.021 and 552.023 of the Government Code, to receive and review the collected information. Under Section 559.004 of the Government Code, you are also entitled to request, in accordance with the agency's procedures, that incorrect information that the agency has collected about you be corrected.</small>			

ALL WITNESSES - COMPLETE THE FOLLOWING

On _____ at about _____ (Circle One) AM PM, I was
Date Time

(clearly state your exact location at the time of the alleged accident) _____
_____ when an accident involving the above employee is alleged to have occurred.

CHECK APPLICABLE BOX:

I observed the accident and it occurred in the following manner: _____

Other pertinent information and source: _____

I did not observe the accident; however, information given to me by: _____
(injured employee or witness) indicates it occurred as follows: _____

Other pertinent information and source: _____

I have no knowledge of the occurrence.

Signature

Date

Complete and return this form to the Supervisor **within 24 hours.**

Distribution:

Reportable: ORIGINAL - State Office of Risk Management; COPY - Workers' Compensation Program Area, Human Resources Headquarters;
COPY - Unit/Department Medical File; COPY - Employee.

Not Reportable: ORIGINAL - Unit/Department Medical File; COPY - Employee.

Texas Department of Criminal Justice
SUPPLEMENTAL WORKSHEET
Change in Status for Employees Out on Workers' Compensation

TO BE COMPLETED BY SUPERVISOR

Name of Injured: _____
Last Name First Name MI
 Social Security No.: _____ Unit/Dept. of Assignment: _____
 Human Resources Region of Assignment: _____ Date of Injury: _____

CHECK APPLICABLE BOX FOR CHANGE IN STATUS:

- A. Return to work on: _____
(mm/dd/yyyy – Date of First Full Shift Employee Returned to Work)
 Full Duty ****or**** Alternate/Modified Duty
- B. Accepted or rejected offer of temporary alternate/modified duty on: _____
(mm/dd/yyyy)
 Current leave designated as FML: Yes ****or**** No
- C. Additional days of workers' compensation disability beginning: _____
(mm/dd/yyyy – Date of First Full Shift of Lost Time Due to the Injury)
 Due to: _____ Expiration of Twelve (12) Weeks Alternate/Modified Duty on: _____
 _____ Reached Maximum Medical Improvement (MMI) _____
 _____ Return to Work Program Not Applicable

SUPERVISOR:

(Please Print) Last Name First Name MI Title

 Signature Date

TO BE COMPLETED BY HUMAN RESOURCES REPRESENTATIVE

- D. Exhausted sick/vacation leave balance on: _____
mm/dd/yyyy (Only required if employee chose C-80 Part A, Election 1.)
- E. Approval of Extended Sick Leave with Pay on: _____ Through: _____
(mm/dd/yyyy) (mm/dd/yyyy)
- F. Approval of Sick Leave Pool on: _____ Through: _____
(mm/dd/yyyy) (mm/dd/yyyy)
- G. Placed on approved leave without pay, WC on: _____ ****or**** FML on: _____
(mm/dd/yyyy) (mm/dd/yyyy)
 FML Notification Sent on: _____
(mm/dd/yyyy)
- H. Change in approved leave without pay, FML exhausted on: _____
(mm/dd/yyyy)
 Placed on leave without pay, WC on: _____ ****or**** _____
(mm/dd/yyyy)
 Placed on active payroll to run vacation time on: _____
(mm/dd/yyyy)
- I. Resignation or Separation Effective: _____ Reason: _____
(mm/dd/yyyy)
- J. Death: _____
(mm/dd/yyyy)

If report is being submitted more than 24 hours after the change in status, provide a reason for late reporting:

Distribution:
 ORIGINAL - E-mail or Fax to the Workers' Compensation Program Area, Human Resources Headquarters within 24 hours of change in status;
 COPY - Unit/Department Medical File;
 COPY - Risk Management Coordinator;
 COPY - Employee.