THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY

Workers' Compensation Network
Acknowledgement Form

I have received the Notice of Network Requirements which informs me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the IMO Med-Select Network®. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.

2. I must go to my network 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. The insurance carrier will pay the treating doctor and other network providers.

4. I may have to pay the bill if I get health care from someone other than a network doctor without network approval.

5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, I am still required to use the network.

Please fill out the following information before signing and submitting this completed acknowledgement form:

Name of Carrier: **THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY**

Employee ID #: _____ Name of Network: **IMO Med-Select Network***

Hire Date: _____ Department: _____

Home Address: _____
Street Address - No P.O. Box or Work Address

_____
City State Zip Code County

_____ _____
Employee Signature Date

_____ _____
Print Name: Employee Phone Number

If any questions, call Environmental Health Safety & Risk Management:
Send Completed Form Immediately to
EHSRM Office
Attn: Celia Saenz
EEHSB 1111
Phone: 956-665-3690
FAX: 956-665-2699

Rev. 11/17/2016

THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY

Detailed description of Injury/Incident

To be completed by the **EMPLOYEE**

A. EMPLOYEE INFORMATION:

Injured Employee Name: _____ Email Address: _____

Home Address: _____ City/State/Zip: _____

SS#: _____ DOB: _____ SEX (M/F) _____ Phone #: _____

Marital Status: ☐ Married Spouse Name: _____

☐ Widowed ☐ Single ☐ Separated ☐ Divorced

B. DEPARTMENT INFORMATION:

Department Name: _____ Supervisor: _____

Job Title: _____ Campus Location (City): _____ Campus Phone #: _____

C. INJURY INFORMATION:

Date of Injury: _____ Location of Injury: _____ Time of Injury: _____ ☐ AM ☐ PM

Type of Injury: ☐ **INCIDENT ONLY** *(No medical attention at this time)* ☐ **MEDICAL TREATMENT ***

* Who did **YOU** select as your treating doctor/facility within the network? _____

Who witnessed the injury/accident/incident? If any, list Names(s) and Campus or Home phone number(s).

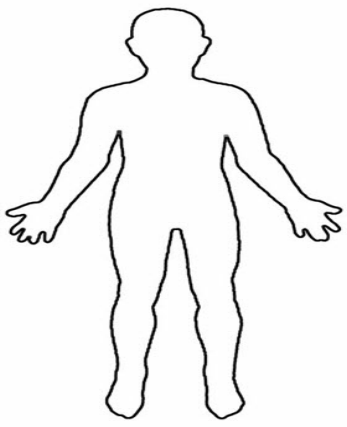
_____

1. Explain how and why this injury occurred: (Provide as much detail as possible.) * Use additional page, if necessary.

Did you notify your supervisor? ☐ Yes ☐ No If YES, **Date** and **Time** of Notification: _____ _____ ☐ AM ☐ PM

☐ Burn ☐ Cut/Laceration ☐ Bruise ☐ Strain ☐ Fall ☐ Needlestick ☐ Repetitive Motion ☐ Exposure

☐ Other _____

☐	LEFT	RIGHT	☐
☐ Ankle			☐ Head
☐ Foot			☐ Face
☐ Lower Leg			☐ Nose
☐ Upper Leg			☐ Eye(s)
☐ Hip			☐ Mouth
☐ Knee			☐ Neck
☐ Shoulder			☐ Upper Back
☐ Upper Arm			☐ Lower Back
☐ Lower Arm			☐ Buttocks
☐ Elbow			☐ Abdomen (Including Groin)
☐ Wrist			☐ Pelvis
☐ Hand			☐ Chest
☐ Fingers			

Please designate the injured body part(s) as reported above.

CERTIFICATION: The above statement is true and accurate to the best of my knowledge:

Injured Employee Signature: _____ Date: _____

Disclosure of your Social Security Number ("SSN") is required in order for The University of Texas System to report as required to the Texas Department of Insurance as mandated by state law. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY
Detailed description of Injury/Incident
To be completed by the **SUPERVISOR**

D. SUPERVISOR

Was medical treatment given to the employee? ☐ Yes ☐ No

Has the employee lost time from work due to this injury? ☐ Yes ☐ No If yes, date lost time began: _____

Has the employee returned to work? ☐ Yes ☐ No If yes, date returned to work: _____

Was the employee given the opportunity to choose their treating network physician? ☐ Yes ☐ No

Accident Information

Yes	No	
☐	☐	1. Did the injury occur because the employee was not following the proper procedures?
☐	☐	2. Did the injury occur because the employee was not wearing the proper personal protective equipment (ppe)?
☐	☐	3. Did the injury occur because the employee was not using the right equipment?
☐	☐	4. Did the injury occur because the employee was not properly trained?
☐	☐	5. Did the injury occur as a result of an unsafe condition (something beyond your control)?

Explain the steps that will be taken to ensure an injury does not occur again.

E. EMPLOYMENT INFORMATION (MUST BE FILLED BY SUPERVISOR)

Does the employee speak English? ☐ Yes ☐ No If NO, what language? _____

Injured employee's date of hire: _____ Occupation of Injured Worker: _____

Employee's Pay Rate: _____ **Number of hours usually worked per week:** _____

Supervisor Signature: _____ Date: _____

Print Name: _____

Email Address: _____ Campus Phone #: _____

Send completed form immediately to
EHSRM Office ~ Attn: Celia Saenz ~EEHSB 1111 ~~ Fax: 956-665-2699

For any questions, call Environmental Health Safety & Risk Management:
Phone: 956-665-3690