MFISD INJURY REPORT FORM REVISED 01/2023

Name of Person Injured: _____

Date of This Report: _____ Time of this Report: _____ am / pm

Date of Injury: _____ Time of Injury: _____ am / pm

Place of Injury: _____

NATURE OF INJURY

Abrasion _____
Bruise _____
Burn _____
Cardiac problem _____
Concussion/head injury _____
Cut/ puncture _____
Dislocation/fracture _____
Electrical shock _____
Inflammation/swelling _____
Insect bite/sting _____
Poisoning _____
Respiratory problem _____
Spinal injury _____
Sprain/strain _____
Other (specify) _____

PART OF BODY INJURED

		Right	Left
Abdomen		Ankle	
Back		Arm	
Chest		Ear	
Face		Elbow	
Finger		Eye	
Head		Foot	
Mouth		Hand	
Nose		Knee	
Scalp		Leg	
Tooth		Wrist	

Other (specify) _____

DESCRIPTION OF ACCIDENT **Please attach additional comments / information on back of sheet**

What was the person doing: _____

How did the injury occurred: _____

Was the proper safety equipment/gear being used: _____

Specify any tool, machine or equipment involved: _____

List any specifically unsafe acts and unsafe conditions existing: _____

Is there anything I could have done to prevent this injury: _____

List all Witnesses: _____

IMMEDIATE ACTION TAKEN

I know it is my responsibility to report any injury to my Supervisor the day of the injury or the first thing the following morning.

Signature of injured party _____ **Date** _____

Signature of Supervisor/Nurse _____ Date _____

Did Employee go to the Doctor? _____

Employee Email _____

Employee Phone Number _____

Health Care Provider
Injury Notification Form

Attention: Healthcare Provider

Please be advised that the employee reference below has claimed a workers' compensation injury or illness.

Employee Name	
SSN (LAST 4 ONLY)	**XXX-XX-**
Date of Injury	

You may provide reasonable, necessary and related medical treatment for the claimed injury or illness. Treatment must be within the Texas Official Disability Guidelines (ODG) for the sustained injury or illness. If the treatment recommended is not within the ODG, preauthorization is required. Please note, per §134.501 pharmaceutical services dispensed within the first 7 days are covered and cannot be denied, prorated or reduced.

Please do not request payment from the injured employee. Your services should be billed to the workers' compensation third party administrator:

Edwards Claims Administration (ECA)
1004 Marble Heights Drive
Marble Falls, TX 78654
Phone: 830-693-2728
Fax: 830-693-2729

Please note: ECA does NOT have a network. We are subscribers.

Treatment requiring preauthorization should be sent to the workers' compensation third party administrator's utilization review organization:

Review Med
Phone: 800-201-1021
Fax: 866-400-7790

Prior to the injured employee leaving your office, please distribute a DWC-73 (Work Status Report) per Workers' Compensation Rules to:

1. The injured employee at the time of the examination via hand delivery,
2. Edwards Claims Administration within 2 working days via fax: 830-693-2729, and
3. Marble Falls ISD (employer) within 2 working days also via fax: 830-693-5685.

For further questions or confirmation of this injury or illness you may contact the assigned workers' compensation adjuster Eloise Trevino or Charlotte Hunter at 830-693-2728 or eloise@edwardsrisk.com; charlotte@edwardsrisk.com .

Thank you!