

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 Mikala Haiduk 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](http://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,



Cassandra Richardson  
Ector County, Claims Coordinator  
432-498-4011  
[haidumj@co.ector.tx.us](mailto:haidumj@co.ector.tx.us)

# **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)**



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 **Jl 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 **Jl 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](mailto: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](http://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.**