Houston Independent School District – Workers' Compensation
EMPLOYEE INJURY AND TREATMENT (EIT) FORM

Please **fax** to Workers' Compensation at (713) 556-9224 or **email** to HISDWorkComp@houstonisd.org
If you have any questions, please call: 713-556-9200

Employee Information

Name (Last, First, M.I.)	Employee ID Number	Employee's Job Title
Home Street Address, City, State, Zip Code		
Gender ☐ Female ☐ Male	Date of Birth	Contact Number
If Employee does not speak English, please specify Language.		

Incident Information

Date of Injury	Time of Injury AM PM	Date Reported	Date Lost Time Began	Date Return to Work

Department or Campus Where Accident or Illness Exposure Occurred	Where did the injury/illness happen (classroom, hallway, etc.)
Department or Campus Street Address, City, State, Zip Code	Campus Contact Number

☐ North Division ☐ South Division ☐ Central Division ☐ West Division

Explain how the injury/illness occurred?	Injured Body Part(s)
List Witness Name(s), Job Title, and Phone Number	Was the employee doing their regular duties?

Did the employee die?	Was the employee transported by ambulance? *If ambulance was called, please call either number below:*
☐ Yes ☐ No	*During business hours: 713-556-9200 After business hours: 713-314-1470* ☐ *Yes* ☐ *No*

Supervisor/Nurse Information *(Must be completed by injured Employee's Supervisor/Nurse)*

Supervisor's Name	Supervisor's Contact Number	Email
If not supervisor, name and Title of Person Completing Form		

Do you wish to file for Assault Leave? ☐ **Yes** ☐ **No**

Please understand that filling for Assault Leve means you must leave the campus and/or location and seek medical treatment for your injury. You cannot return to duty until you are released by your treating doctor. If you do not mark either Yes or No on the EIT form, we will presume that you do not wish to file for assault leave. You must file for assault leave within 30 calendar days from the date of injury.

TO WHOM IT MAY CONCERN: (1) I herby authorize my health care providers to disclose protected health information to Houston ISD (Self-Insured) or it representative for the purpose of verifying, evaluating, and processing my worker's compensation claim. Although this authorization is not needed to obtain my medical records, I voluntarily sign it for the release of all medical, insurance, and billing records to expedite the handling of my claim. I understand that I have the right to revoke this authorization in writing at any time and the right to inspect or copy the information disclosed. This authorization shall expire when my workers' compensation claim ends. (2) I acknowledge I have received information that tells me how to get health care under the HISD WC 504 Provider Panel.

_____ _____ _____ _____

Injured Employee's Signature Date Supervisor/Nurse's Signature Date

Mitchell ScriptAdvisor

compRx

Workers' Compensation *FIRST FILL* – Temporary Prescription Card

Mitchell ScriptAdvisor has been selected by CCMSI to assist you in obtaining prescription drugs related to your workers' compensation claim. This form enables you to fill prescriptions written by your authorized workers' compensation physician for medications related to your injury. Simply present it at the pharmacy at the time your prescription is filled. This form should ensure that you will have NO out-of-pocket expenses when you fill your first prescription. Please Note: This is a temporary prescription card, you may receive a permanent drug card in the future.

For your convenience, Mitchell ScriptAdvisor has an extensive network of retail pharmacies including major chain drug stores. For pharmacy locations, you may call our toll-free number at 866.846.9279 or visit our website at www.mitchellscriptadvisor.com to access the pharmacy locator.

Employee

- You may contact Mitchell Customer Service at (866) 846-9279 or you may present this sheet to the pharmacist along with your prescription.

Pharmacy

- This sheet is a Temporary Prescription ID Card for a 10 Days' Supply Fill until this individual's permanent card can be provided.
- Create the ID number based off the criteria provided and write it, along with individual's name, on the ID card below.
- All data needed to process this script through the Script Care Adjudication System is included in the drug card represented below.

Mitchell ScriptAdvisor
Temporary Prescription Benefit
SCRIPT CARE, LTD.

Member Name:
Member ID #:
Date of Injury + Date of Birth (Example: MMDDYYMMDDYY)

Rx BIN:	019082
PCN:	MPS
Group:	MPS001150TC

Walmart
RITE AID
Longs Drugs
CVS pharmacy
TARGET
SAFEWAY

Questions?
Contact us at 866.846.9279

This card is to be used for prescriptions related to your workers' compensation injury covered under the workers' compensation insurance policy. Use of this card does not waive any limitations or exclusions for the policy. This card does not confirm coverage. To confirm eligibility or obtain specific information, please contact the Help Desk with the information from the front of this card.

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866.221.658