Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name ______________________________Date of Injury ______________________

Date of Birth________________________________ Social Security ______________________

Reported Work Related Injury or Illness:
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Georgetown ISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB Risk Management Fund
P.O. Box 2010
Austin, TX 78768-2010
Phone: 800.482.7276
Fax: 800.580.6720

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature ______________________________ Title _________________________

Phone Number_________________________________ Date _________________________

Providers please submit Work Status Reports and all Job Description enquiries to:

Ashley Smith, Coordinator of Benefits and Leave
Phone: 512.943.5000 x6092
Fax: 512.943.1894
Email: smitha5@georgetownisd.org

For a full list of Alliance Providers please visit pswca.org.