DEPARTMENT OF HUMAN RESOURCES

505 South McColl Road Suite A • Edinburg, Texas 78539 • (956) 318-2660

CONFIRMATION OF CLAIM FOR A WORK RELATED INJURY
VERIFICATION OF EMPLOYMENT FORM

WORKER'S COMPENSATION CLAIM OF:

Name: _____

Employee ID #: _____

Department: _____

Date of Injury: _____

This is to verify that the above named employee is presently employed by Hidalgo County and is covered under the provisions of the Texas Department of Insurance/Division of Workers' Compensation (TDI/DWC) Act. This employee has reported an on-the-job injury and is entitled to all medical provisions of the act.

If you are the treating physician and are treating this employee for the alleged injury, please provide our office with a DWC Form-73. Indicate the employee's current work status and estimated date of expiration for limitation/restrictions, if any. If the employee is prevented from returning to work, provide an anticipated date of return to work. This form is to be submitted as soon as required by the act.

For questions regarding this claim and billing information, please contact:

TRISTAR RISK MANAGEMENT
P.O. Box 2805
Clinton, IA 52733
(Office) 361-857-0115
(Fax) 361-857-0123

Please fax all DWC Form-73's to (956) 318-2669
Attention: Employee Programs Division
or contact our office at (956) 318-2660 for more information