Liberty County Emergency Medical Services
Application for Employment

We consider applicants for all positions without regard to race, color, religion, sex, national origin, age, disability, or any other legally protected status pursuant to the Texas Employment Discrimination Law, and other relevant federal, state and local laws.

(PLEASE PRINT)

Position(s) Applied for	Date of Application

How Did You Learn About Us?

Advertisement	Friend	Walk-In
Employment Agency	Relative	Other ______________________

Last Name	First Name	Middle Name

Address	City	State	Zip

Telephone Number	Social Security Number

If you are under 18 years of age, can you provide required proof of your eligibility to work? Yes No

Have you ever filed an application with us before? Yes No
If Yes, give date ______________________

Have you ever been employed with us before? Yes No
If Yes, give date ______________________

Are you currently employed? Yes No

May we contact your present employer? Yes No

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? Yes No

On what date would you be available for work? Yes No

Are you available to work: Full Time Part Time Shift Work Temporary

Are you currently on "lay-off" status and subject to recall? Yes No

Can you travel if a job requires it? Yes No

Have you been convicted of a felony within the last 7 years? Yes No
Conviction will not necessarily disqualify an applicant from employment

If Yes, please Explain ____

____

____

Education

	Name and Address of School	Course of Study	Years Completed	Diploma Degree
Elementary School				
High School				
Undergraduate School				
Graduate Professional				
Other Specify				

Indicate any foreign languages you can speak, read and / or write

	Fluent	Good	Fair
Speak			
Read			
Write			

Describe any specialized training, apprenticeship, skills and extra-curricular activities.

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Describe any job-related training received in the United States Military.

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Employment Experience

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations that indicate race, color, religion, gender, national origin, disabilities or other protected status.

Employer	Dates Employed From To	Work Performed
Address		
Telephone number(s)	Hourly Rate / Salary Starting Final	
Job Title	Supervisor	
Reason for Leaving		

Employer	Dates Employed From To	Worked Performed
Address		
Telephone number(s)	Hourly Rate / Salary Starting Final	
Job Title	Supervisor	
Reason for Leaving		

Employer	Dates Employed From To	Worked Performed
Address		
Telephone number(s)	Hourly Rate / Salary Starting Final	
Job Title	Supervisor	
Reason for Leaving		

Employer	Dates Employed From To	Worked Performed
Address		
Telephone numbers(s)	Hourly Rate / Salary *Starting* *Final*	
Job Title	Supervisor	
Reason for Leaving		

Employer	Dates Employed From To	Worked Performed
Address		
Telephone numbers(s)	Hourly Rate / Salary Starting Final	
Job Title	Supervisor	
Reason for Leaving		

APPLICANTS STATEMENT:

I certify that answers given herein are true and correct to the best of my knowledge.I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. This includes all past and current medical conditions. I agree to take a pre-employment physical and the Executive Director and Medical Director may review all information pertaining to such to arrive at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless an authorized executive of this organization specifically acknowledges such change in writing.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Under the provisions of the Fair Credit Reporting Act, 15 USC, Section 1681 et seq., the Americans with Disabilities Act and all applicable federal, state, and local laws, I hereby authorize and permit Liberty County Emergency Medical Services, Inc. to obtain a consumer report and/or an investigative consumer report which may include the following:

1. My employment records;
2. Records concerning any driving, criminal history, civil record, workers' compensation (post-offer only) and drug testing;
3. Verification of my academic and/or professional credentials; and information and/or copies of documents from any military service records.

I understand that an "investigative consumer report" may include information as to my character, general reputation, personal characteristics, and mode of living which may be obtained by interviews with individuals with whom I am acquainted or who may have knowledge concerning any such items of information.

I agree that a copy of this authorization has the same effect as an original.

I hereby release and hold harmless any person, firm or entity that discloses matters in accordance with this authorization, as well as Liberty County Emergency Medical Services, Inc. from liability that might otherwise result from the request for use of and/or disclosure of any or all of the foregoing information.

I hereby authorize Liberty County Emergency Medical Services, Inc. to obtain and prepare an investigative consumer report as set forth above, as part of its investigation of my employment application. This authorization shall remain in effect over the course of my employment. Reports may be ordered periodically during the course of my employment.

____________________________ Signature of Applicant

____________ Date

Additional Information

Other Qualifications
Summarize special job-related skills and qualifications acquired from employment or other experience.

State any additional information you feel may be helpful to us in considering you application.

Note to Applicants: DO NOT ANSWER THE FOLLOWING QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Are you Capable of performing in a reasonable manner, with or without a reasonable accommodation, the activities involved in the job or occupation for which you have applied? A description of the activities involved in such a job or occupation is attached.
__Yes __ No

If you need additional space, please continue on a separate sheet of paper.

List professional, trade, business or civic activities and offices held.
You may exclude membership that would reveal gender, race, religion, national origin, age, ancestry, disability or other protected status:

REFERENCES

Name		Phone #	
Address	City	State	Zip
Name		Phone #	
Address	City	State	Zip
Name		Phone #	
Address	City	State	Zip
Name		Phone #	
Address	City	State	Zip

APPLICANTS STATEMENT:

I certify that answers given herein are true and correct to the best of my knowledge.
I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision. This includes all past and current medical conditions.
I agree to take a pre-employment physical
and the Executive Director and Medical Director may review all information pertaining to such to arrive at an employment decision.
This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.
I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature, which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless an authorized executive of this organization specifically acknowledges such change in writing.
In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.
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I understand that an "investigative consumer report" may include information as to my character, general reputation, personal characteristics, and mode of living which may be obtained by interviews with individuals with whom I am acquainted or who may have knowledge concerning any such items of information.

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I hereby authorize Liberty County Emergency Medical Services, Inc. to obtain and prepare an investigative consumer report as set forth above, as part of its investigation of my employment application. This authorization shall remain in effect over the course of my employment. Reports may be ordered periodically during the course of my employment.

______________________________ ______________

Signature of Applicant Date

For Personnel Department Use Only

Arrange Interview Yes No

Remarks ____________________

____

Interviewer ____________ Date ____________

Employed Yes No Date of Employment ____________

Job Title ____________ Hourly Rate/ Salary ______ Dept ________

By ____________________
Name and Title Date

Position(s) Applied for is Open:
Yes No

Position(s) considered for: ____________________

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Date ____________

Notes:

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Form W-4 (2009)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** ______

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** ______

F Enter "1" if you have at least $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . **F** ______
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children.
- If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children. **G** ______

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

OMB No. 1545-0074 — **2009**

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

1 Type or print your first name and middle initial.	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $ ______

7 I claim exemption from withholding for 2009, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ **7** ______

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(Form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

OMB No. 1115-0136

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification.
To be completed and signed by employee at the time employment begins.

Print Name: Last | First | Middle Initial | Maiden Name

Address *(Street Name and Number)* | Apt. # | Date of Birth *(month/day/year)*

City | State | Zip Code | Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A___________
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) ____________

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature | Print Name

Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 2. Employer Review and Verification.
To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

	List A	OR	List B	AND	List C
Document title:	________		________		________
Issuing authority:	________		________		________
Document #:	________		________		________
Expiration Date *(if any)*:	__/__/__		__/__/__		__/__/__
Document #:	________				
Expiration Date *(if any)*:	__/__/__				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* ___/___/___ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative | Print Name | Title

Business or Organization Name | Address *(Street Name and Number, City, State, Zip Code)* | Date *(month/day/year)*

Section 3. Updating and Reverification.
To be completed and signed by employer.

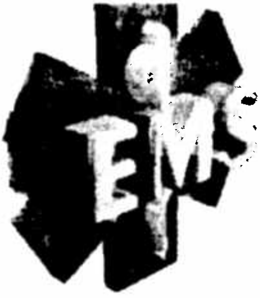
A. New Name *(if applicable)* | B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

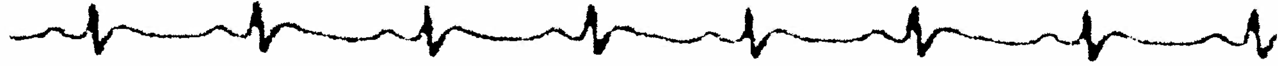
Document Title: ________ Document #: ________ Expiration Date (if any): __/__/__

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date *(month/day/year)*



Liberty County Emergency Medical Services
P.O. Box 351   Hull, Texas   77564



DRUG TESTING PROGRAM
SAFETY AND QUALITY #1

This is to authorize ____ ,
An employee of Liberty County Emergency Medical Services, Inc. to be screened for durgs and alcohol at Liberty Dayton Hospital, through the Liberty County Emergency Medical Services, Inc. employee drug testing program.

________________________________ ____________________________

Authorizing Supervisor Date

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, I understand that:

1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995 to notify them of my choice.
2. I must go 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. The insurance carrier will pay the treating doctor and other network providers.
4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

_______________________________________ ______________
Signature Date

____
Printed Name

I live at: _______________________________________
Street Address

____

____
City State Zip Code

Name of Employer: _______________________________________

Name of Network: *Texas Star Network®*

Network service areas are subject to change.
Call (800) 381-8067 if you need a network treating provider.

Please indicate whether this is the:

☐ Initial Employee Notification

☐ Injury Notification (Date of Injury: ____/_____/_____)

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Texas Star Network®
Employee Notice of Network Requirements

Important Contact Information:

To locate a provider, call (800) 381-8067

To contact Texas Mutual Insurance Company, visit www.texasmutual.com or call (800) 859-5995

Texas Star Network®

Information, Instructions and your Rights and Obligations

Dear Employee:

Your employer has chosen *Texas Star Network*® to manage the health care and treatment you may receive if you are injured at work. *Texas Star Network*® is a certified workers' compensation health care network. The state of Texas has approved this network to provide care for work related injuries. This program includes a network of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely. The current *Texas Star Network*® service areas are shown on the enclosed map.

If you are injured at work, tell your supervisor or employer immediately. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment through *Texas Star Network*®. You may also contact Texas Mutual Insurance Company for any questions about your care and treatment for a work related injury. Texas Mutual and your employer have formed a team to provide timely health care for injured workers. The goal is to return you to work as soon as it is safe to do so.

Your Rights and Obligations...

Choosing a Treating Doctor

If you are hurt at work and you live in the network service area, you must choose a treating doctor from the *Texas Star Network*® provider list. This is required for you to receive coverage of the costs for the care of your work related injury. A provider listing is available through our website at www.texasmutual.com. It is updated at least every three months. It identifies providers who are taking new patients.

You also have the option to choose your current health maintenance organization (HMO) primary care physician as the treating doctor for your workers' compensation claim. In order for your HMO doctor to be approved as your treating doctor, he/she must agree to the terms of the network contract, and to agree to abide by applicable laws and regulations. If your HMO doctor is not approved, then you must see a network treating doctor.

If you were injured before your insurer contracted with the network and you live in the service area, you must choose a network treating doctor. You may also request a doctor you chose as your HMO primary care doctor before you were hurt. You must do this upon receipt of this notice.

If your treating doctor leaves the network, we will tell you in writing. You will have the right to choose another treating doctor from the list of network doctors. If your doctor leaves the network

and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra 90 days.

If you believe you live outside of the service area, you may request a service area review by calling Texas Mutual Insurance Company. Within 7 days of receiving your request for review, we will tell you our decision. If you do not agree with our final decision you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, telephone number, a copy of the insurer's decision and any proof you sent to Texas Mutual Insurance Company for review. A complaint form is available on the department's web site at www.tdi.state.tx.us. You may also ask for a form by writing to the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

While waiting for Texas Mutual Insurance Company to make a decision or the Texas Department of Insurance to review your complaint, you may choose to receive health care outside of the network. You may be required to pay for health care services received out of the network if it is finally decided that you do live in the network's service area.

Changing Doctors

If you become dissatisfied with your first choice of a treating doctor, you can select an alternate treating doctor from the list of network treating doctors in the service area where you live. *Texas Star Network®* will not deny a choice of an alternate treating doctor. Before you can change treating doctors a second time, you must get permission from *Texas Star Network®*.

Referrals

You do not have to get a referral if you have an emergency health condition. All health care services that you request will be made available by the network on a timely basis, as required by your medical condition. This includes referrals. All health care services, including referrals, will be made available no more than 21 days after you make a request.

Payment for Health Care

Network doctors have agreed to look to Texas Mutual Insurance Company for payment for your health care. They will not look to you for payment. If you obtain health care from a doctor who is not in the network without prior approval from *Texas Star Network®*, you may have to pay for the cost of that care. You may only access non-network health care providers and still be eligible for coverage of your medical costs if one of the following situations occurs.

- Emergency care is needed. You should go to the nearest hospital or emergency care facility.
- You do not live within a *Texas Star Network®* service area.
- Your treating doctor refers you to an out of network provider or facility. This referral must be approved by *Texas Star Network®*.
- You have chosen your HMO primary care doctor. Your doctor must agree to abide by the network contract and applicable laws.

Complaints

You have the right to file a complaint with *Texas Star Network*®. You may do this if you are dissatisfied with any aspect of network operations. This includes a complaint about your network doctor. It may also be a general complaint about *Texas Star Network*®.

A complainant can notify the *Texas Star Network*® Grievance Coordinator of a complaint by phone or in writing via mail or fax. Complaints should be forwarded to:

***Texas Star Network*®**
Attention: Grievance Coordinator
720 Cool Springs Boulevard, Suite 300
Franklin, TN 37067

Phone: (800) 873-0055 ext 4250
FAX: (615) 224-9129
E-mail: grievance_coordinator@cvty.com

A complaint must be filed with the network grievance coordinator no later than 90 days from the date the issue occurred.

Texas law does not permit *Texas Star Network*® to retaliate against you if you file a complaint against the network. *Texas Star Network*® also can not retaliate if you appeal the decision of the network. The law does not permit *Texas Star Network*® to retaliate against your treating doctor if he or she files a complaint against the network or appeals the decision of the network on your behalf. You have the right to file a complaint with the Texas Department of Insurance. The Texas Department of Insurance complaint form is available on the department's web site at www.tdi.state.tx.us or you may request a form by writing to:

HMO Division, Mail Code 103-6A,
Texas Department of Insurance,
P. O. Box 149104, Austin, Texas 78714-9104.

What to do if you are injured while on the job...

If you are injured while on the job tell your employer as soon as possible. A list of network treating doctors in your service area may be available from your employer. A complete list of network treating doctors is also available online at www.texasmutual.com. Or, you may contact us directly at the following address and/or toll-free telephone number:

Texas Star Network®
720 Cool Springs Boulevard
Suite 300
Franklin, TN 37067
(800) 873-0055

We will help you get an appointment with a network doctor.

In case of an emergency...

If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility.

After you receive emergency care, you may need ongoing care. You will need to select a treating doctor from the network's provider list. This list is available online at www.texasmutual.com. If you do not have internet access call (800) 381-8067 or contact your employer for a list. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care...

Report your injury to your employer as soon as you can. Select a treating doctor from the network's provider list. This list is available online at www.texasmutual.com. If you do not have internet access, call (800) 381-8067 or contact your employer for a list.

Treatment prescribed by your doctor may need to be approved in advance. You or your doctor are required to request approval from Texas Mutual Insurance Company for a specific treatment or services before the treatment or service is provided. You may continue to need treatment after the approved treatment is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

The following treatment requests must be approved in advance (effective 2/5/07):

All surgeries (CPT codes 1-6 and G codes which represent a surgical procedure) with a billed amount greater than $500.00. PreAuth Request should include specific hardware to be used for the procedure. • Artificial Disc Surgery • Intradiscal Electrothermal Annuloplasty (IDET)	Implantable drug delivery system
Chemonucleolysis	Injections (Botox Injections, Epidural Steroid Injection, Facet Injection, Joint Steroid Injection, RFTC or cryotherapy/cryoblation of any nerve or joint, Sacral Iliac joint injection, Trigger Point Injections, Radiofrequency Thermocoagulation (RFTC) of facet joints)
Chiropractic treatments greater than 8 visits	Investigational or experimental procedures or devices
Bone Density Scans	Manipulations under anesthesia
Myelograms	Stimulator Devices including, but not limited to TENS units, Interferential units, Neuromuscular stimulators, Dual units, Spinal Cord Stimulator, Dorsal Column Stimulator, Peripheral nerve Stimulator, Brain Stimulator
Discograms	Nursing home: Skilled nursing facility, including skilled care within the same facility, Convalescent care, Residential care
Surface Electromyography (EMG)	Orthotic Devices - billed amount more than $150.00
Durable medical equipment (DME) greater than $500.00 billed (purchase or accumulated rental or combination of rental/purchase)	Physical Therapy/Occupational Therapy Greater than 14 visits
External and implantable bone growth stimulators	Acupuncture/Acupressure
Gym memberships	Psychological testing and Psychotherapy evaluations, testing, therapy and biofeedback
Home health care visits/services	Rehab Programs (including, but not limited to): Work Conditioning greater than 2 weeks Work Hardening greater than 2 weeks Chronic Pain Management Program Medical Rehabilitation Brain and Spinal Cord Rehabilitation
Non-emergency inpatient hospital services including principle scheduled procedures and length of stay	Weight loss programs
Chemical Dependency Programs	

The number to call to request one of these treatments is (888) 532-5246. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Texas Star Network® Service Area Map (As of November 2007)
Network service areas are subject to change

– A list of the counties in the network service area is contained on the next page –

Texas Star Network® Service Area County List (As of November 2007)

Network service areas are subject to change

ANDERSON	DUVAL	KENDALL	REEVES
ANDREWS	EASTLAND	KENEDY	REFUGIO
ANGELINA	ECTOR	KERR	ROBERTS
ARANSAS	EL PASO	KLEBERG	ROBERTSON
ARCHER	ELLIS	LAMAR	ROCKWALL
ARMSTRONG	ERATH	LAMB	RUNNELS
ATASCOSA	FALLS	LAMPASAS	RUSK
AUSTIN	FANNIN	LAVACA	SABINE
BANDERA	FAYETTE	LEE	SAN AUGUSTINE
BASTROP	FORT BEND	LEON	SAN JACINTO
BAYLOR	FRANKLIN	LIBERTY	SAN PATRICIO
BEE	FREESTONE	LIMESTONE	SAN SABA
BELL	FRIO	LIPSCOMB	SCHLEICHER
BEXAR	GAINES	LIVE OAK	SCURRY
BLANCO	GALVESTON	LLANO	SHACKELFORD
BORDEN	GARZA	LOVING	SHELBY
BOSQUE	GILLESPIE	LUBBOCK	SHERMAN
BOWIE	GLASSCOCK	LYNN	SMITH
BRAZORIA	GOLIAD	MADISON	SOMERVELL
BRAZOS	GONZALES	MARION	STARR
BRISCOE	GRAY	MARTIN	STEPHENS
BROOKS	GRAYSON	MASON	STERLING
BROWN	GREGG	MATAGORDA	SWISHER
BURLESON	GRIMES	MCCULLOCH	TARRANT
BURNET	GUADALUPE	MCLENNAN	TAYLOR
CALDWELL	HALE	MCMULLEN	TERRY
CALHOUN	HALL	MEDINA	THROCKMORTON
CALLAHAN	HAMILTON	MENARD	TITUS
CAMERON	HANSFORD	MIDLAND	TOM GREEN
CAMP	HARDIN	MILAM	TRAVIS
CARSON	HARRIS	MILLS	TRINITY
CASS	HARRISON	MITCHELL	TYLER
CASTRO	HARTLEY	MONTAGUE	UPSHUR
CHAMBERS	HASKELL	MONTGOMERY	UPTON
CHEROKEE	HAYS	MOORE	VAN ZANDT
CLAY	HENDERSON	MORRIS	VICTORIA
COKE	HIDALGO	NACOGDOCHES	WALKER
COLEMAN	HILL	NAVARRO	WALLER
COLLIN	HOCKLEY	NEWTON	WARD
COLORADO	HOOD	NOLAN	WASHINGTON
COMAL	HOPKINS	NUECES	WEBB
COMANCHE	HOUSTON	OCHILTREE	WHARTON
CONCHO	HOWARD	OLDHAM	WICHITA
COOKE	HUNT	ORANGE	WILBARGER
CORYELL	HUTCHINSON	PALO PINTO	WILLACY
CRANE	IRION	PANOLA	WILLIAMSON
CROSBY	JACK	PARKER	WILSON
DALLAM	JACKSON	PARMER	WINKLER
DALLAS	JASPER	PECOS	WISE
DAWSON	JEFFERSON	POLK	WOOD
DEAF SMITH	JIM HOGG	POTTER	YOAKUM
DELTA	JIM WELLS	RAINS	YOUNG
DENTON	JOHNSON	RANDALL	
DEWITT	KARNES	REAGAN	
DONLEY	KAUFMAN	RED RIVER	