PROVIDER NOTIFICATION OF A WORK-RELATED INJURY OR OCCUPATIONAL DISEASE

This form shall act as notification for workers' compensation insurance coverage. This form is to be presented to the physician's office, hospital emergency department, or other authorized provider that is treating you for your work-related injury.

This notice is to inform you that _____
(Injured employee's name)

has claimed a work-related injury or occupational disease that occurred on _____.
(Date of injury)

This employee's injury or occupational disease may be covered by Workers' Compensation Insurance through the University of Texas System. All claims are handled by CCMSI. This form does not certify compensability or guarantee payment.

For Workers' Compensation consideration **Please submit all bills and medical reports, or questions to:**	**The University of Texas System c/o CCMSI** **Cannon Cochran Management Services, Inc.** **P. O. Box 802082** **Dallas, Texas 75380** **Phone: 1.888.396.6844** **FAX: 217.477.6813**
For Provider Referrals	**Injury Management Organization (IMO)** **214.217.5939 or 888.466.6381** **FAX: 214.217.5937 or 877.946.6638** **Email: CSRNetwork@injurymanagement.com**
For Preauthorization Request	**888.645.1200 or 972.404.8133** **Fax: 888.275.9946**

Tracy Gardner
_____ _____
Supervisor or Authorized Department Delegate **Date**

UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F401
11/2023

University of Texas at Arlington

Employee's Report of Work-Related Injury or Occupational Disease

Personal Information:

Employee Name: _____ UT EID: _____ Email Address: _____

Home Phone: _____ Mailing Address: _____ City: _____Zip: _____

Work ext. or best number to reach you during working hours: _____

Date of Birth: _____ □ Male □ Female Race: □ Black □ White □ Asian □ NA

Marital Status: □ Married □ Unmarried □ Separated Spouse's Name: _____ □ NA # Dependent Children? _____ □ NA

Position/Title: _____ Department Where Employed: _____

Incident Information:

Date of Injury: _____ Time of Injury: _____ □ a.m. □ p.m. Date Supervisor was notified: _____

Direct Supervisor's Name: _____ Direct Supervisor Contact Number: _____

Name of management you reported the injury to, if different than direct supervisor: _____

Contact Number: _____

Worksite location of injury (Ex.: Administration Bldg., Sidewalk, Corridor by 2nd floor elevators, Lab, etc.)

Building/Room#_____ Description of Area_____

If off campus, location and physical address: _____

Describe below how the injury or exposure occurred. (Ex.: I left my office walking to the elevator, my shoe caught on carpeted hallway, and I tripped/fell striking right shoulder on floor OR I struck the top of my left hand with a screwdriver while trying to put together a desk for my office.)

Describe the resulting 'physical' injury (s) (Ex.: sprained left ankle, bruised left shoulder, laceration on top of head)

Did anyone witness the injury? Yes □ No □ List witness name (s) and contact information below.

1. _____ Contact # or email _____

2. _____ Contact # or email _____

3. _____ Contact # or email _____

Please select all body parts where you were injured and check the appropriate boxes.

	Left	Right	Both			Left	Right	Both
Abdome/Stomach ☐	☐	☐	☐		**Head** ☐	☐	☐	☐
Ankle ☐	☐	☐	☐		**Hip** ☐	☐	☐	☐
Arm ☐ **upper** ☐ **lower** ☐	☐	☐	☐		**Knee** ☐	☐	☐	☐
Back ☐ **upper** ☐ **lower** ☐	☐	☐	☐		**Leg** ☐ **upper** ☐ **lower** ☐	☐	☐	☐
Buttocks ☐	☐	☐	☐		**Multiple Body Parts** ☐	☐	☐	☐
Chest (includes ribs/sternum) ☐	☐	☐	☐		**Neck** ☐	☐	☐	☐
Ear ☐	☐	☐	☐		**Nose** ☐	☐	☐	☐
Elbow ☐	☐	☐	☐		**Sacrum/Coccyx Tailbone** ☐	☐	☐	☐
Eye ☐	☐	☐	☐		**Shoulder** ☐	☐	☐	☐
Face ☐	☐	☐	☐		**Throat** ☐	☐	☐	☐
Foot ☐	☐	☐	☐		**Teeth** ☐	☐	☐	☐
Hand ☐	☐	☐	☐		**Wrist** ☐	☐	☐	☐
Finger thumb ☐ **index** ☐ **middle** ☐ **ring** ☐ **little (pinky)** ☐					**Toe 1st** ☐ **2nd** ☐ **3rd** ☐ **little toe** ☐ **great toe** ☐			

Medical Information:

Please complete and return the Workers' Compensation Network Acknowledgement Form which informs you how to get healthcare under workers' compensation insurance. Please review the Notice of Network Requirements and obtain the WC Pharmacy First Fill /Text2Fill form.

I have been offered medical treatment but do not wish to receive any now. Initials_____
I understand this does not prevent me from seeking medical treatment later.

If seeking initial medical treatment, please provide the information below:

_____
Clinic or Hospital Name

_____
Physician

_____
Phone

_____
Address of clinic:

The above statement is true and accurate to the best of my knowledge. I confirm that the accident described above happened while I was performing duties that were assigned to me by UTA (University of Texas Arlington).

I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with the Environmental Health and Safety and/or other UTA/UT System depts. for improvements in workplace safety and preventing accidents and injury. It may also be shared with Office of Talent, Culture, and Inclusion for designation of Family Medical Leave, if applicable.

Injured Employee's Signature_____ Date _____

Scan and email completed form to workerscompensation@uta.edu.

The University of Texas at Arlington

Workers' Compensation Network Acknowledgement Form

I have received information (Notice of Network Requirements & Employee Handbook Material) which informs me how to get Health Care under Workers' Compensation Insurance.

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

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®.*** (A list of physicians can be found at www.injurymanagement.com) Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network 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 *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

Name of Carrier: The University of Texas System **Name of Network:** IMO Med-Select Network®

Home Address:_____

Street Address – No P.O. Box or Work Address

_____

City **State** **Zip Code** **County**

_____ _____ _____

Printed Name **Date of Injury** **Employee Phone Number**

_____ _____ _____

Employee Signature **Date** **Email**

For more information please contact the office of Environmental Health & Safety at (817) 272-2185

RxBridge

THE UNIVERSITY OF TEXAS AT ARLINGTON
FIRST FILL PRESCRIPTION CARD

Upon receiving prescriptions for a work-related injury for one of your employees, please provide the injured worker with a copy of this instruction sheet or ask them to text **UTA00** to toll free 833-FRSTFILL (833-377-8345). The injured worker will complete the process and then present their billing information via mobile device.

Please follow the below instructions to obtain your First Fill Prescription Card.

Text

UTA00

to 833-377-8345

How it Works

01

Text

Text **UTA00** to toll free
833-FRSTFILL (833-377-8345)

02

Follow the On-Screen Step by Step Instructions

Step 1: Text your First and Last Name
Step 2: Text your Date of Injury
Step 3: Confirm Information

03

Receive First Fill Card

You will receive an image of your prescription card right to your phone.

04

Fill Your Prescriptions

Present your First Fill Prescription Card along with your injury related prescription(s) to your local pharmacy.

If you encounter any problems filling your prescriptions or to find a participating retail pharmacy, please call RxBridge at 833-RxBridge (833-792-7434) or use our pharmacy locator at www.RxBridge.com

UT System

IMO Med-Select Network® Quick Reference Card for Injured Employees

The method to get Healthcare Services under UT System's Workers' Compensation Insurance

IMO Med-Select Network® is the Network in which you will use to gain access to medical care for your injury.

IMO Network Main Line or Find a Provider:

- 214.217.5939 or 888.466.6381

Or you may visit IMO's website at:

- https://injurymanagement.com/find-a-provider/

For emergency care you may seek treatment at the nearest emergency facility.

Following notification of an injury on the job, an IMO Telephonic Case Manager, CCMSI Claims Professional/Adjuster, UT System Supervisor & RxBridge are parties to provide assistance to injured employees with medical case management and processing your workers' compensation claim. Early contacts and communication are important to ensure a smooth process and facilitate your recovery.

IMO Telephonic Case Manager (TCM):
This individual will be your assistance with facilitating medical care and helping you throughout the Network process.

CCMSI Claims Professional:
Responsible for daily claim handling including payment processing and communication with institution representatives.

UT System Claims Supervisor:
Oversees claim handling and provides continuous review/audit of all claim files.

RxBridge:
This is the party who will help you get the prescriptions you may need through the course of your injury.

For more information about IMO please visit: www.injurymanagement.com

Important IMO Network Reminders:

- Acknowledgment Form — Provided by your institution, you are required to complete at the time of new hire and at the time an injury occurs. Please be sure to sign this.
- Except in medical emergencies, injured employees are required to select a treating doctor from the IMO provider panel.
- For any questions regarding your specialist or treating doctor please reach out to your IMO telephonic case manager.

We are here to assist you. Please reach out with questions to:
IMO General Network/Provider Questions or to reach TCM's:

Phone: 214.217.5939
Fax: 214.217.5937
Email: netcare@injurymanagement.com

CCMSI (UT's Third Party Administrator Adjuster Services)

Address: PO Box 802082, Dallas, TX 75380
Phone: 888.802.0692
Fax: 217.477.6813

RxBridge (Pharmacy Services)

Contact Number: 1.833.792.7434

If you have a need for Telemedicine Services please search the IMO Provider Directory and choose the Telemedicine provider option. Some of these providers are available 24/7 to treat your work-related injury.

Your employer may have many options for return to work if you are given restrictions by your provider and may have the ability to accommodate. Please reach out to your institution's workers' compensation representative regarding this.

For additional information on Network requirements please access the UT System Workers' Compensation Insurance website at:
https://www.utsystem.edu/offices/risk-management/workers-compensation-insurance-0

UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F402
11/2023

Supervisor's Report of Employee Work-Related Injury or Occupational Disease

Personal Information:

Name of Injured Employee: _____ Employee Extension: _____ Does not have personal extension □

What is the best number to contact employee? _____

Does your injured employee speak English? Yes □ No □ If no, what language? _____

Job Information:

Employee's Position/Title: _____ Dept. Where Employed: _____

Length of service in current position:_____ Employee's normal work week (Ex.: Mon-Fri, 7am - 4pm, no lunch) _____

Please provide the current leave balances as of the date of injury. Sick: _____ *Vacation:* _____ *Compensatory:*_____

Incident Information:

Date of Injury: _____ Time of Injury: _____ a.m. □ p.m. □

When were you notified about this injury? Date: _____ Time: _____ a.m. □ p.m. □

Are you the employee's direct supervisor? Yes □ No □ If no, who is the direct supervisor? _____

Has your employee missed a full workday(s) because of this injury (excluding the day of injury)? Yes □ No □

Excluding the day of injury, what was the first scheduled workday missed? _____ N/A □

Return to work date (if known):_____

Worksite where injury happened (Ex: Administrative Bldg., Sidewalk, 2nd floor elevators, Lab):

Building/Room # _____

Description of Area _____

Based on your inquiry, what was your employee doing at the time of the injury. *(Ex.: "The employee stated he was walking into the building, slipped on the wet tile and fell to his knees causing a bruise to his left knee").*

When the injury happened, was your employee performing their regular duties or a specific task assigned to them? Yes □ No □

If no, please describe what they were doing at the time of the reported injury.

Was there physical evidence of injury to the claimed body parts? Yes □ No □ N/A □

If yes, please describe (Ex.: scratch on upper left arm, cut to top of head/scalp, bruised right knee)

Were there any witnesses to this injury? Yes □ No□ If yes, list name(s) and phone number(s). Attach an additional sheet, if necessary.

1. _____ Contact # or email _____

What do you think may prevent this type of accident from happening in the future?

Medical Information:

Did you provide the employee the required WC Network Acknowledgement form & Notice of Network Requirements packet on how to get healthcare under workers' compensation insurance? Yes □ No □

Initial Medical Treatment: Yes □ No □ First Aid Only Yes □ No □ Physician/Treatment Facility Yes □ No □ ER Visit Yes □ No □

Supervisor's Signature: (**Required):** _____Date: _____

Print Supervisor's Name: _____Ext._____Supervisor's Email Address: _____

This form was completed by ***(if other than the supervisor)***:

Print Name _____ Ext: _____Email Address: _____

Scan completed forms and email to workerscompensation@uta.edu

Please be aware that signing this report is not an admission by or evidence against UT Arlington. The information contained in this report only documents the supervisor's knowledge or version of how this incident occurred.

(You may be entitled to know what information The University of Texas at Arlington (UT Arlington) collects concerning you. You may review and have UT Arlington correct the information according to procedures set forth in UTS 139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.)

Revised: 11/23

IMO MED-SELECT NETWORK®

A Certified Texas Workers' Compensation Health Care Network

Notice of Network Requirements for The University of Texas System

IMO Med-Select Network®
Notice of Network Requirements

1. *The University of Texas System* is using a certified workers' compensation health care network called the **IMO Med-Select Network®.**

2. For any questions you may contact IMO by:

   a. Calling IMO Med-Select Network® at 888.466.6381
   b. Writing to P.O. Box 260287, Plano, Texas 75026
   c. E-mailing questions to netcare@injurymanagement.com

3. Each certified workers' compensation network must have one or more service areas where doctors and other health care workers are available to treat you if you are hurt on the job. The network's service areas are in the following counties:

IMO Med-Select Network®								
Anderson	Burleson	Crosby	Glasscock	Hunt	Liberty	Newton	Shackelford	Ward
Andrews	Burnet	Dallas	Goliad	Irion	Limestone	Nolan	Shelby	Washington
Angelina	Caldwell	Delta	Gonzales	Jackson	Live Oak	Nueces	Smith	Wharton
Aransas	Calhoun	Denton	Grayson	Jasper	Llano	Orange	Somervell	Wichita
Archer	Callahan	DeWitt	Gregg	Jefferson	Lubbock	Panola	Starr	Willacy
Atascosa	Cameron	Ector	Grimes	Jim Wells	Lynn	Parker	Sterling	Willbarger
Austin	Camp	El Paso	Guadalupe	Johnson	Madison	Polk	Tarrant	Williamson
Bandera	Cass	Ellis	Hale	Jones	Marion	Rains	Taylor	Wilson
Bastrop	Chambers	Falls	Hardin	Karnes	Martin	Reagan	Terry	Winkler
Baylor	Cherokee	Fannin	Harris	Kaufman	Matagorda	Red River	Titus	Wise
Bee	Clay	Fayette	Harrison	Kendall	McLennan	Refugio	Tom Green	Wood
Bell	Coke	Fisher	Hays	Kenedy	Medina	Robertson	Travis	
Bexar	Coleman	Floyd	Henderson	Kerr	Menard	Rockwall	Trinity	
Blanco	Collin	Fort Bend	Hidalgo	Kleberg	Midland	Runnels	Tyler	
Bosque	Colorado	Franklin	Hill	Lamar	Milam	Rusk	Upshur	
Bowie	Comal	Freestone	Hockley	Lamb	Montague	Sabine	Upton	
Brazoria	Concho	Frio	Hood	Lampasas	Montgomery	San Augustine	Van Zandt	
Brazos	Cooke	Galveston	Hopkins	Lavaca	Morris	San Jacinto	Victoria	
Brewster	Coryell	Garza	Houston	Lee	Nacogdoches	San Patricio	Walker	
Brooks	Crane	Gillespie	Howard	Leon	Navarro	Schleicher	Waller	

4. A map of the service area with the above counties can also be viewed on the IMO website at **www.injurymanagement.com** or on page seven of this Notice of Network Requirements packet.

5. You have the right to select your HMO primary care physician (PCP) as your treating doctor if your HMO PCP was selected prior to your injury at work. The network prefers that you make this decision as soon as possible. Your HMO PCP must agree to abide by the workers' compensation health care network's contract and rules.

6. Except for emergencies, if you are hurt at work and live in the network service area, you must choose a treating doctor from the list of network doctors. All services and referrals are to be received from your treating doctor.

7. Except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to you on a timely basis and within the time appropriate to the circumstances and your condition, but no later than 21 days after the date of the request.

8. If you need emergency care, you may go anywhere. If you become injured after business hours and it is not an emergency, go to the closest health care facility.

9. If you cannot contact your treating doctor after business hours, and you are in need of urgent care, go to the closest health care facility.

10. You may not live in the network service area. If so, you are not required to receive care from network providers.

11. If you are hurt at work and you do not believe that you live within the network service area, contact your claims adjuster. The Third-Party Administrator for UT System must review the information within seven calendar days and notify you of their decision in writing.

12. UT System may agree that you do not live in the network service area**.** If you receive care from an out-of-network provider, you may have to pay the bill for health care services if it is later determined that you live in the network service area.

13. If you disagree with the decision in regard to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #30 below.

14. Even if you believe you do not live in the network service area, you still may receive health care from network doctors and staff while your complaint is reviewed by the Texas Department of Insurance and the network.

15. UT System will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may have to pay the bill if you get care from someone other than a network doctor without approval.

16. All network doctors and other providers will only bill UT System for medical services as related to the compensable work injury. The employee should not be billed by the network provider.

17. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:

    a. Admission to a hospital or surgical procedures
    b. Mental Health Care
    c. Physical Medicine Services such as physical therapy, occupational therapy, and chiropractic
    d. Diagnostic testing
    e. Injections

f. Rehabilitation Programs including work conditioning and work hardening
g. Durable Medical Equipment billed at more than $1,000 per item
h. Treatment not addressed or not recommended by Evidence Based Guidelines
i. Prescription drugs on the "N" list and all compounds
j. Dental
k. Investigational treatment
l. Pain Medicine / Other Programs
m. Treatment for Disputed Body Parts & Conditions
n. Miscellaneous: – K-Wire removal, Chemotherapy, Radiation

18. Definition: "Adverse Determination" means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are *not* medically necessary or appropriate.

19. If the proposed health care services are for concurrent hospitalization, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are pre-authorized. For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination no later than three business days after the date the request is received.

20. If the network issues an adverse determination of the request for health care services, you, a person acting on your behalf or your doctor may file a request for reconsideration by writing a letter or calling the network. Even though you can request a reconsideration of the denial yourself, the network encourages you to talk to your doctor about *filing* the reconsideration. He or she may have to send medical information to the network. This reconsideration must be submitted within 30 days of the date that your doctor receives the adverse determination in writing.

21. The network will respond to the reconsideration request within five business days of receipt demonstrating that the network has received the information. The network has up to 30 business days for the final determination. If it is a reconsideration request for concurrent review, the network will respond within three business days. The network will respond within one business day if it is a reconsideration request which involves a denial of proposed health care services involving post-stabilization treatment, life-threatening conditions or for continued length of stay in a facility.

22. Independent Review Organization (IRO) exemption: An employee with a life-threatening condition is entitled to an immediate review by an IRO and is *not* required to comply with the procedures for a reconsideration of an adverse determination.

23. If the network renders an adverse determination on a reconsideration of the following: i) a preauthorization review, ii) a concurrent review or iii) a retrospective review, the notification will include information on how to request an IRO. Requests for an IRO must be sent no later than 45 days from the date of the denial of the reconsideration.

24. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting in your behalf, or the requesting provider may request a review by an IRO. IRO requests shall be made to the Texas Department of Insurance on behalf of the patient by the Utilization Review Agent (URA).

25. An IRO review may be requested for several other reasons besides a life-threatening situation. The reasons may include: i) if the network denies the health care a second time by denying your reconsideration; ii) if the network denies the referral made by your treating doctor because it is not medically necessary; or iii) if the network denies your care because it is not within treatment guidelines.

26. After the review by the IRO, they will send a letter explaining their decisions. UT System will pay the IRO fees.

27. Your treating doctor may decide to leave the network. If so, and if it may harm you to immediately stop the doctor's care, UT System must pay your treating doctor for up to 90 days of continued care.

28. If you are dissatisfied with any part of the network, you can file a complaint. Any complaint must be filed within 90 days of the event that you are dissatisfied. When a complaint is received, you will be sent a notification letter within seven days, which will describe the complaint procedures. The network will review and resolve the complaint within 30 days of receipt. *You can contact the network by:*

    a. Calling: 877.870.0638
    b. Writing: IMO Med-Select Network®
       Attention : NetComplaint Dept.
       P.O. Box 260287
       Plano, TX 75026
    c. E-mailing: netcomplaint@injurymanagement.com

29. The network will not retaliate if:

    a. An employee or employer, who files a complaint against the network or appeals a decision of the network, or
    b. A provider who, on behalf of the employee, files a complaint against the network or appeals a decision of the network.

30. If you file a complaint with the network and are dissatisfied with the network resolution, you may file an appeal with the Texas Department of Insurance (TDI). *You can receive a complaint form from:*

    a. The TDI website at www.tdi.state.tx.us, or
    b. Write to TDI at the following address:
       Texas Department of Insurance
       HMO Division, Mail Code 103-6A
       P.O. Box 149104
       Austin, TX 78714-9104

31. Within five business days, the network will send a letter confirming they received the appeal.

32. A list of network providers will be updated every three months, including:

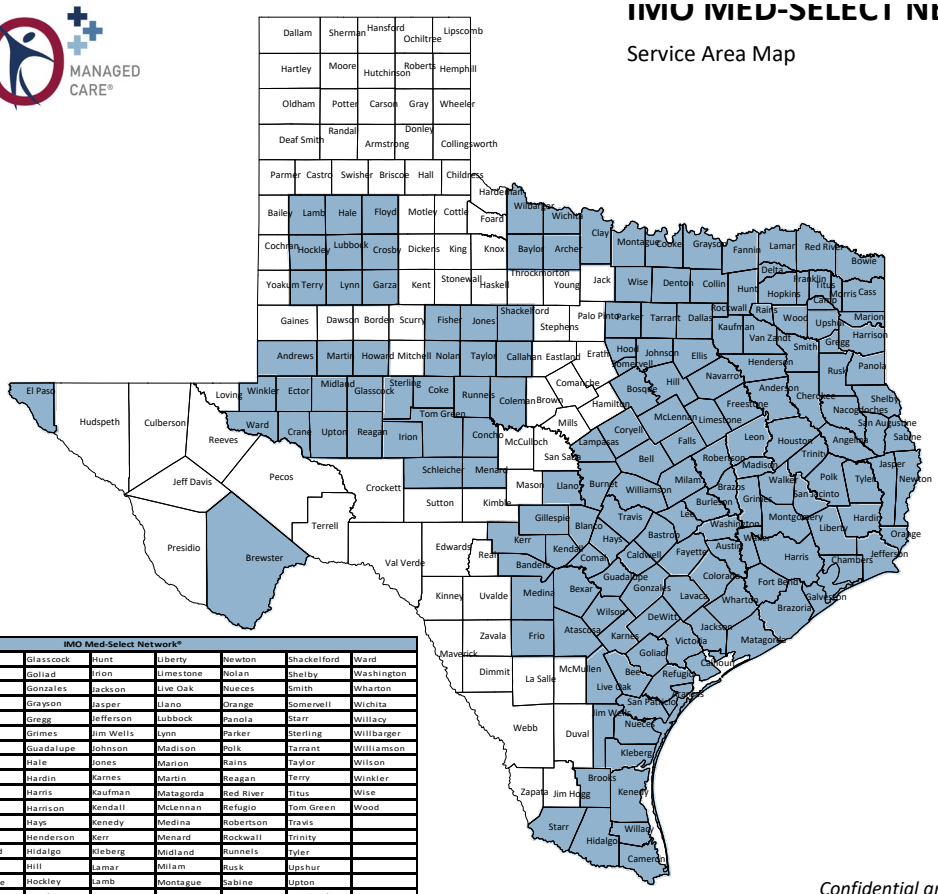
    a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
    b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.

33. To obtain a provider directory:

    a. You can request a copy from your employer, or
    b. You can view, print or email a list online at www.injurymanagement.com.

IMO MED-SELECT NETWORK®

Service Area Map



IMO Med-Select Network®								
Anderson	Burleson	Crosby	Glasscock	Hunt	Liberty	Newton	Shackelford	Ward
Andrews	Burnet	Dallas	Goliad	Irion	Limestone	Nolan	Shelby	Washington
Angelina	Caldwell	Delta	Gonzales	Jackson	Live Oak	Nueces	Smith	Wharton
Aransas	Calhoun	Denton	Grayson	Jasper	Llano	Orange	Somervell	Wichita
Archer	Callahan	DeWitt	Gregg	Jefferson	Lubbock	Panola	Starr	Willacy
Atascosa	Cameron	Ector	Grimes	Jim Wells	Lynn	Parker	Sterling	Willbarger
Austin	Camp	El Paso	Guadalupe	Johnson	Madison	Polk	Tarrant	Williamson
Bandera	Cass	Ellis	Hale	Jones	Marion	Rains	Taylor	Wilson
Bastrop	Chambers	Falls	Hardin	Karnes	Martin	Reagan	Terry	Winkler
Baylor	Cherokee	Fannin	Harris	Kaufman	Matagorda	Red River	Titus	Wise
Bee	Clay	Fayette	Harrison	Kendall	McLennan	Refugio	Tom Green	Wood
Bell	Coke	Fisher	Hays	Kenedy	Medina	Robertson	Travis	
Bexar	Coleman	Floyd	Henderson	Kerr	Menard	Rockwall	Trinity	
Blanco	Collin	Fort Bend	Hidalgo	Kleberg	Midland	Runnels	Tyler	
Bosque	Colorado	Franklin	Hill	Lamar	Milam	Rusk	Upshur	
Bowie	Comal	Freestone	Hockley	Lamb	Montague	Sabine	Upton	
Brazoria	Concho	Frio	Hood	Lampasas	Montgomery	San Augustine	Van Zandt	
Brazos	Cooke	Galveston	Hopkins	Lavaca	Morris	San Jacinto	Victoria	
Brewster	Coryell	Garza	Houston	Lee	Nacogdoches	San Patricio	Walker	
Brooks	Crane	Gillespie	Howard	Leon	Navarro	Schleicher	Waller	

0 75

Scale in Miles

October 2022

Confidential and Proprietary