Division of Workers' Compensation

Complete if known:

DWC claim #

Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)

2. Address (street or PO box, city, state, ZIP code)

3. Phone number

4. Email address

5. Social Security number

6. Date of birth

7. Marital status

8. Sex ☐ Female ☐ Male ☐ Other

9. Spouse's name (first, middle, last)

10. Number of dependent children

11. Does the employee speak English? ☐ Yes ☐ No **If no, specify language**

12. Doctor's name (first, last)

13. Doctor's mailing address (street or PO box, city, state, ZIP code)

Part 2: Injury information

14. Date of injury or illness (mm/dd/yyyy)

15. Time of injury : ☐ a.m. or ☐ p.m.

16. First day absent from work (mm/dd/yyyy)

17. Supervisor's name (first, last)

18. Date injury reported (mm/dd/yyyy)

19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)

20. Body parts affected

21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)

22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)

23. Was the employee doing their regular job? ☐ Yes ☐ No

24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)

25. List all witnesses (first, last names)

26. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

27. Return-to-work date (mm/dd/yyyy)

☐ Actual date or ☐ Expected date

28. Did the employee die? ☐ Yes ☐ No

If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)

30. Occupation of injured employee

31. Length of service in current position

Years Months

32. Length of service in current occupation

Years Months

33. Employee payroll classification code

34. Was the employee hired or recruited in Texas?

☐ Yes ☐ No

35. Rate of pay at this job

$ Hourly $ Weekly

36. Full work week is

Hours Days

37. Last paycheck was

$ for Hours or Days

38. Is the employee an owner, partner, or corporate officer? ☐ Yes ☐ No

Part 4: Employer information

39. Name and title of person completing form
(first, middle, last, title)

40. Business name

41. Business mailing address (street or PO box, city, state, ZIP code)

42. Phone number

43. Email address

44. Business location (if different from mailing address)

45. Federal employer identification number

46. Primary North American Industry Classification System (NAICS) code (six digits)

47. Specific NAICS code (six digits)

48. Texas comptroller taxpayer number

49. Workers' compensation insurance carrier

50. Policy number

51. Did you request accident prevention services in the past 12 months? ☐ Yes ☐ No

If yes, did you receive them? ☐ Yes ☐ No

Part 5: Certification

52. Certify with your signature:

I certify the information in this form is true and correct.

Signature______________________________ **Date**__________________