

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

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| CLAIM # _____ |
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| CARRIER'S CLAIM # _____ |
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EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

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|--|----------------------|--|--------|
| 1. Name (Last, First, M.I.) | | 2. Sex F <input type="checkbox"/> M <input type="checkbox"/> | |
| 3. Social Security Number - - | 4. Home Phone () | 5. Date of Birth (m-d-y) - - | |
| 6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> | | 8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/> | |
| 9. Mailing Address Street or P.O. Box | | | |
| City | State | Zip Code | County |
| 10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> | | | |
| 11. Number of Dependent Children | | 12. Spouse's Name | |
| 13. Doctor's Name | | | |
| 14. Doctor's Mailing Address (Street or P.O.Box) | | | |
| City | State | Zip Code | |

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|--|---|---|----------------------------------|
| 15. Date of Injury (m-d-y) - - | 16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/> | 17. Date Lost Time Began (m-d-y) - - | |
| 18. Nature of Injury* | | 19. Part of Body Injured or Exposed* | |
| 20. How and Why Injury/Illness Occurred* | | | |
| 21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. Worksite Location of Injury (stairs, dock, etc.)* | |
| 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site | | | |
| Street or P.O. Box | | County | |
| City | State | Zip Code | |
| 24. Cause of Injury(fall, tool, machine, etc.)* | | | |
| 25. List Witnesses | | | |
| 26. Return to work date/or expected (m-d-y) - - | 27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> | 28. Supervisor's Name | 29. Date Reported (m-d-y) - - |

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|--|---|---|--|
| 30. Date of Hire (m-d-y) - - | 31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/> | 32. Length of Service in Current Position Months _____ Years _____ | 33. Length of Service in Occupation Months _____ Years _____ |
| 34. Employee Payroll Classification Code | | 35. Occupation of Injured Worker | |
| 36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly | 37. Full Work Week is: _____ Hours _____ Days | 38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days | 39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/> |

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|--|--|--|------------------------------------|
| 40. Name and Title of Person Completing Form | | 41. Name of Business | |
| 42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone () | | 43. Business Location (If different from mailing address) Number and Street | |
| City | State | Zip Code | City State Zip Code |
| 44. Federal Tax Identification Number | 45. Primary North American Industry Classification System Code:(6 digit) | 46. Specific NAICS Code (6 digit) | 47. Texas Comptroller Taxpayer No. |
| 48. Workers' Compensation Insurance Company | | 49. Policy Number | |

50. Did you request accident prevention services in past 12 months?
YES NO If yes, did you receive them? YES NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

