

Send the specified copies to your
Workers' Compensation Insurance Carrier
 and the injured employee
***Employers - Do not send this form to the
 Texas Workers' Compensation Commission,
 unless the Commission specifically requests a direct filing**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) <input style="width: 100%;" type="text"/>		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number <input style="width: 100%;" type="text"/>	4. Home Phone <input style="width: 100%;" type="text"/>	5. Date of Birth (m-d-y) <input style="width: 100%;" type="text"/>	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/> Language <input style="width: 100%;" type="text"/>			
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 <input style="width: 100%;" type="text"/> Street or P.O. Box <input style="width: 100%;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> 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 <input style="width: 100%;" type="text"/>		12. Spouse's Name <input style="width: 100%;" type="text"/>	
13. Doctor's Name <input style="width: 100%;" type="text"/>			
14. Doctor's Mailing Address (Street or P.O. Box) <input style="width: 100%;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> City State ZIP Code			

15. Date of Injury (m-d-y) <input style="width: 100%;" type="text"/>	16. Time of Injury <input style="width: 20px;" type="text"/> am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y) <input style="width: 100%;" type="text"/>
18. Nature of Injury* <input style="width: 100%;" type="text"/>		19. Part of Body Injured or Exposed* <input style="width: 100%;" type="text"/>
20. How and Why Injury/Illness Occurred* <input style="width: 100%; height: 40px;" type="text"/>		
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>	22. Worksheet Location of Injury (stairs, dock, etc.)* <input style="width: 100%; height: 40px;" type="text"/>	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site <input style="width: 100%;" type="text"/> Street or P.O. Box <input style="width: 100%;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> City State ZIP Code County		
24. Cause of Injury (fall, tool, machine, etc.)* <input style="width: 100%;" type="text"/>		
25. List Witnesses <input style="width: 100%; height: 20px;" type="text"/>		
26. Return to work date/or expected (m-d-y) <input style="width: 100%;" type="text"/>	27. Did employee Die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name <input style="width: 100%;" type="text"/>
		29. Date Reported (m-d-y) <input style="width: 100%;" type="text"/>