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.)
2. Sex F ☐ M ☐
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 ☐ NO ☐
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
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

15. Date of Injury (m-d-y) - -
16. Time of Injury : am ☐ pm ☐
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 ☐ NO ☐
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 ☐ NO ☐
28. Supervisor's Name
29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -
31. Was employee hired or recruited in Texas? YES ☐ NO ☐
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 ☐ NO ☐

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 ( )
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary Standard Industrial Classification (SIC) Code* (4 digit)
46. Specific SIC Code* (4 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 _____