

Mail this form to:  
 STATE OFFICE OF RISK MANAGEMENT  
 P. O. Box 13777  
 Austin, Texas 78711

TWCC CLAIM # \_\_\_\_\_

SORM CLAIM # \_\_\_\_\_

Please read instruction sheet CAREFULLY,  
 giving special attention to items marked  
 with an asterisk (\*).

**EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS**

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		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)		
3. Social Security Number	4. Home Phone ( )		5. Date of Birth (m-d-y)		18. Nature of Injury*		19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>								
7. Employee Telephone #			8. Block no longer used					
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				Telephone #				
14. Doctor's Mailing Address (Street or P.O.Box)								
City		State		Zip Code				
21. Was employee doing his/her 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 (Name, Telephone #)								
26. Return to work date (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)		

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 Years _____ Months _____		33. Length of Service in Occupation Years _____ Months _____	
34. State Payroll Classification Code			35. Occupation of Injured Worker				
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly \$ _____ Monthly		37. Full Work Week is: _____ Hours _____ Days		38. Last Paycheck was: \$ _____		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

40. Name and Title of Person Completing Form Claims Coordinator			41. Name of Agency				
42. Agency Mailing Address and Telephone Number Street or P.O. Box Telephone ( )			43. Agency Location Code ____ / ____ / ____ Name of Location: _____				
City		State		Zip Code			
44. Federal Tax Identification Number		45. Primary Standard Industrial Classification Code (SIC)* (4 digit)		46. Specific SIC Code* (4 digit)		47. Comptroller Agency Code ____	
48. Workers' Compensation Insurance Company <b>State Office of Risk Management</b>				49. Policy Number <b>TXSTATEPOL001</b>			
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>				52. Number of Hours of Sick/Annual Leave Credited to Employee on Date of Injury			
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)							