

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 | | | | | |
| 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 Accident/Injury Occurred* | | | | | | | | | |
| 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 North American Industrial Classification System Sector Code (NAICS) (2 digits) | | 46. Specific NAICS Code | | 47. Comptroller Agency Code _____-_____-____- | | | |
| 48. Workers' Compensation Insurance Company State Office of Risk Management | | | | 49. Policy Number TXSTATEPOL001 | | | | | |
| 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) | | | | | | | | | |



Employer's First Report of Injury Instruction Sheet

The Employer's first report of injury form **must** be submitted **within 24 hours** in order to meet state stipulated deadlines. Failure to submit the necessary forms on a timely basis may delay medical and income benefits to the injured employee and may result in administrative fines to the University.

The "Employer's first Report of Injury or Illness" (TWCC-1S):

- This form is to be completed by the injured employee's direct supervisor.
- Supervisors should complete boxes: 1-38, 50 and 52.
- The information requested on lines 13 and 14 should be provided only if a physician was seen as a result of the accident; if no physician was seen type "NONE" on line 13 and leave line 14 blank.
- If the employee does not return to work the next working day the supervisor must contact the Risk Management Administrator with this information.
- Please do not mail this form to the State Office of Risk Management (SORM) as the Risk Management Administrator will electronically submit the form to SORM.
- The form should be sent as follows:

Email: Eudoh@uh.edu

Fax: 713-743-8035

Mail Code: 1005