Texas A&M University

Instructions for Completing the Employers First Report of Injury or Illness Form (DWC 1)

Note: The **Employers First Report of Injury or Illness form (DWC 1)** is not a Texas A&M University form. It is an official form of the State of Texas. An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00.

The Employers First Report of Injury or Illness is to be filled out by the employee's immediate supervisor or designee and faxed to the TAMU Workers' Compensation Office (WCO) at (979) 847-8546 within 24 hours.

The First Report of Injury or Illness provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

If handwriting the information, it must be legible and in black ink. It is preferable that the form be typed using capital letters in large bold font. Where dates are required enter MM/DD/YY (example: 08/15/04). If you need assistance when completing this form, contact the WCO staff at hrwci@tamu.edu or (979) 862-4028.

Block # 1 Enter last name, first name, middle initial

Block # 2 *Indicate male or female (**Article 8308 – 2.13(e) Texas Workers' Compensation Act* requires the Texas Workers' Compensation Commission to maintain information as to the race, ethnicity, and sex on every compensable injury. This information is maintained for non-discriminatory statistical use.

Block # 3 Enter Social Security number

Block # 4 Enter phone number where employee may be contacted, including area code

Block # 5 Enter birth date

Block # 6 Indicate if the employee speaks English. If the employee speaks another language, indicate the language.

Block # 7 *Indicate the employee's race. Ask the employee for their preference or use your best estimate if the employee if unavailable.

Block # 8 *Indicate the employee's ethnicity

Block # 9 Enter current mailing address (please include zip code)

Block # 10 Indicate marital status

Block # 11-14 are preferred, but may be left blank if unknown

Block # 15 Indicate date of injury

Block # 16 Indicate time of injury and AM or PM

Block # 17 Indicate date lost time began (not including date of injury) or indicate no lost time as NLT

Block # 18 Indicate nature of injury (fall, slip, strain, laceration, contusion, etc.), or type of exposure (radiation, chemical, etc), or if occupational illness

Block # 19 Indicate body part involved in injury (foot, mouth, back, etc.)

Block # 20 Provide brief but specific description of how injury occurred

Block # 21 Indicate if the employee was working within the course and scope of their position description

Block # 22 Indicate work location of injury (dock area, kitchen area, outside area, parking area, etc.)

Block # 23 List name of department

Block # 24 Indicate the cause of injury or exposure (slippery floor, machinery malfunction, contact with chemical, etc.)

Block # 25 List only first-hand observers willing to testify

Block # 26 Indicate date employee returned to work or is expected to return to work, if known

Block # 27 Indicate if the employee died from the injury or illness. If yes, then notify WCO by phone at (979) 862-4028 immediately.

Block # 28 Provide name of employee's immediate supervisor

Block # 29 Enter date injury was reported

Block # 30 Enter employee date of hire

Block # 31 Indicate if employee was hired in Texas

Block # 32 Enter length of service in current position

Block # 33 Ask employee to determine the total length of time in the occupation, including length of service with The Texas A&M University System and outside employers

Block # 34 Enter employee's 4-digit job classification code

Block # 35 Enter employee's job title

Block # 36 Enter employee current rate of pay by hour and by week

Block # 37 Enter hours worked each week (40 hours at 5 days or 20 hours at 5 days, etc.)

Block # 38 Enter amount of employee's last paycheck (gross) and indicate the number of hours worked. If monthly employee enter the number of days worked.

Block # 39 Indicate "No"

Block # 40 Enter name of HR liaison/contact person

Block # 41 Enter Texas A&M University

Block # 42 Enter departmental address and phone number

Block # 43 Enter TAMU Human Resources Address (1111 Research Pkwy, 77843-1255)

Block # 44 Enter TAMU Tax ID # 74-6000-531

Block # 45-47 Leave blank

Block # 48 Enter The Texas A&M University System – Self-Insurance (Carrier)

Block # 49 Enter self-insured

Block # 50 Leave blank

Block # 51 Enter signature of person completing form and date of completion

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.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	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? YES ☐ NO ☐ If No, Specify Language			20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box City State Zip Code County			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		
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐					
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code			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 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 _____

Injured Worker Rights & Responsibilities IW

Information for Injured Workers from the Division of Workers' Compensation

What is Workers' Compensation?

Workers' compensation is a state-regulated insurance program that pays your medical bills and replaces a portion of your lost wages if:

- you are injured at work or have a work-related illness; and
- your employer has workers' compensation insurance under the Texas Workers' Compensation Act.

Workers' compensation will pay for the medical treatment of your work-related injury or illness if:

- your employer has workers' compensation insurance coverage under the Texas Workers' Compensation Act; and
- your injury occurs at work or you have an illness related to your job.

Workers' compensation will also replace a portion of your lost wages if:

- your work-related injury or illness causes you to lose all or some of your wages for more than seven (7) days from one or more jobs.

What are my Rights?

[Section 409.010, Rule 120.2]

1. You may have the right to receive benefits.

You may receive benefits regardless of who caused or helped cause your work-related injury. You may not receive benefits if:

- you were injured while in a state of intoxication;
- you willfully attempted to injure yourself or unlawfully injure another person;
- you were injured for a personal reason by someone who was not a co-worker;
- you were injured while participating in a voluntary off-duty recreation, social, or athletic activity that was not part of your duties as an employee;
- the injury arose out of an act of God; or
- horseplay caused the injury.

2. You have the right to receive medical care that is necessary to treat your work-related injury or illness.

   You and your doctor can discuss what medical treatment will help to ensure a quick recovery and return to work. In most cases, the longer you remain off work, the harder it can be for you to return to productive employment. Many injured workers can return to work and perform modified or altered duty work even though they are not completely recovered. Remaining active at work can help you recover faster so you can resume all your normal life activities.

3. You have the right to an initial choice of doctor.

   The doctor you choose must be on the Approved Doctor List (ADL). You may access the Division's ADL online at www.tdi.state.tx.us/wc/information/locatedoctor.html. Then click on "TXCOMP Healthcare Provider System". Place the cursor on main menu, and then click on "Locate Doctor". If you do not have access to the Internet, you may contact Customer Assistance at 1-800-252-7031 and request a list of Division approved doctors in your area to be mailed or faxed to you.

   After you have chosen your first treating doctor, you may not change doctors except with the approval of the Division. Any request to change doctors must be approved by the local Division office handling your claim. If you or your doctor move or your doctor becomes unavailable to provide medical treatment, you will be allowed to choose another doctor from the ADL. This will be considered an exception to the law and will not be viewed as a request to change doctors. You will need to complete an *Employee's Request to Change Treating Doctors* (DWC Form-53) and file it with the local Division office.

For further assistance, call
1-800-252-7031
or visit
www.tdi.state.tx.us

paid.

Your treating doctor may refer you to other doctors on the ADL for medical treatment without the need to request to change doctors through the Division.

4. You have the right to receive information about and assistance with your claim.

Division staff will explain your rights and responsibilities as an injured worker under the Texas Workers' Compensation Act. You can request Ombudsman assistance from the Division. Ombudsmen are Division employees in your local Division office that can help you with resolution of a dispute on your claim after a proceeding has been scheduled. You may ask for help from an Ombudsman if you have not hired an attorney to represent you and you do not have any other type of representation. Ombudsmen may not give you legal advice. In addition, Ombudsmen may not make any decisions for you or sign agreements or forms. Ombudsman services are provided to you at no charge. You may request ombudsman assistance by contacting Customer Assistance at 1-800-252-7031.

5. You have the right to hire an attorney to help you get benefits or resolve disputes.

You may hire an attorney to represent you for your claim. An attorney may attend dispute resolution proceedings with you to present any evidence that supports your side of the dispute. You may contact the State Bar of Texas for assistance in obtaining an attorney to represent you at www.texasbar.com or by phone at 1-800-252-9690.

If you hire any attorney, fees will be deducted from your income benefit payments as ordered by the Division. The attorney's fees are limited to no more than 25 percent of the total amount of your income benefits, and payments may not exceed 25 percent of any one income benefit check.

An attorney may charge up to a maximum of $150 per hour, plus expenses, for work performed on your workers' compensation claim. If you dismiss your attorney for any reason, the fees that have been ordered by the Division will continue to be deducted from your income benefit payments until all ordered fees have been

6. You have the right to confidentiality.

Only people who need to know, such as your attorney or representative, employer, or your employer's insurance carrier, may see all of the information contained in the Division's files about you.

If an employer that has workers' compensation insurance is considering hiring you, the employer can file a *Prospective Employment Authorization and Certification* (DWC Form-156) with the Division to obtain general information about previous work-related injuries. Information will only be provided if you, the applicant, have had two or more injuries in the last five (5) years. To obtain this information, the prospective employer must have written permission from you and have made a conditional offer of employment.

If you want a family member or friend to discuss your claim with Division staff, you must provide written approval to the Division for them to do so.

With a few exceptions, you are entitled by law to know, review, and correct information that the Division collects on its forms about you. For more information, you may contact the Division at 1-800-372-7713, extension 4636.

What are My Responsibilities?

[Section 409.010, Rule 120.2]

- You have the responsibility to tell your employer about your work-related injury or illness.
- You must tell your employer within 30 days of the date you were injured, or within 30 days of the date when you first knew your illness might be work-related.
- If you do not tell your employer about your work-related injury or illness within 30 days, you could lose your right to get benefits.

1. You have the responsibility to fill out an *Employee's Notice of Injury or Occupational Disease and*

Claim for Compensation (DWC Form-41) and send it to the Division.

You must complete an *Employee's Notice of Injury or Occupational Disease and Claim for Compensation* (DWC Form-41) within one (1) year of the date you were injured, or within one (1) year of the date you first knew your illness might be work related. You can print this form by clicking above on DWC Form-41, fill out the form, and mail it to the address provided on the form. Or, you may file this form through our website: www.tdi.state.tx.us/wc/indexwc.html. To file this form online, click on : "Report an Injury" under the "Worker" portion of the webpage. You should file the DWC Form-41 even if you are already receiving benefits.

If you do not send a completed DWC Form-41 to the Division within one (1) year, you could lose the right to get benefits.

2. You have the responsibility to tell the Division and insurance carrier any time your income changes.

After your work-related injury or illness, regardless of whether or not you are receiving income benefits, notify the insurance carrier if:

- you have changed employers; or
- your income has increased or decreased.

You must report any income (other than workers' compensation benefits you may be receiving) to the Division and the insurance carrier so an adjustment can be made to your income payments. You may be fined or charged with fraud if you receive temporary income benefits or supplemental income benefits while also receiving wages from an employer without informing the Division and the insurance carrier.

3. You have the responsibility to tell the doctor how you were injured and if you believe the injury may be work-related.

You should tell the doctor about the injury or illness and whether it may be work related **before** receiving medical treatment.

4. You have the responsibility to tell the Division and insurance carrier how to contact you.

You should contact the Division and insurance carrier if your home address, work address, or telephone number changes, so that the Division and insurance carrier may contact you when necessary.

For more information on Workers' Compensation for injured workers, see the following fact sheets:

- Workers' Compensation In Texas
- Travel Reimbursement
- Workers' Compensation Benefits
- Dispute Resolution
- Benefit Review Conference
- Contested Case Hearing
- Appeals Panel Review
- Judicial Review