

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 filing.

CLAIM # _____
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CARRIER'S CLAIM # _____
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### EMPLOYERS 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	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 wrk 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 Ccde		35. Occupation of Injured Worker	
36. Rate of Pay at this Job Hourly      Weekly	37. Full Wrk 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		43. Business Location (If different from mailing address) Number and Street	
City      State      Zip Code		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 \_\_\_\_\_



## INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. 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 filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed \$500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. 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 filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

### "SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

- Items 2,7,8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Items 5,15,17,26,29,30: Enter data in month, day, year format. Example: 08-13-54.
- Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
- Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
- Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
- Items 32,33: Enter date in month-year format. Example: 02-56.
- Item 37: Enter the number of days or hours that make up a full work week for your employees.
- Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
- Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

