

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 #	
CARRIER'S CLAIM #	

EMPLOYERS 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 XXX-XX-	4. Home Phone ()	5. Date of Birth (m-d-yyyy) - -		18. Nature of Injury* Choose an item.		19. Part of Body Injured or Exposed* Choose an item.	
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>				20. How and Why Injury/Illness Occurred*			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 City State Zip Code			
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>				24. Cause of Injury (fall, tool, machine, etc.)*			
11. Number of Dependent Children		12. Spouse's Name		25. List Witnesses			
13. Doctor's Name				26. Return to work date/or expected (m-d-y) - -			
14. Doctor's Mailing Address (Street or P.O. Box) City State Zip Code				27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. Supervisor's Name	
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 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 <input type="checkbox"/> No <input type="checkbox"/>	
40. Name and Title of Person Completing Form				41. Name of Business Texas A&M University			
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()				43. Business Location (If different from mailing address) Number and Street Texas A&M University Human Resources (1255 TAMU) City State Zip Code College Station, TX 77843-1255			
44. Federal Tax Identification Number 74-6000-531		45. Primary North American Industry Classifications System Code (6 digit) XXXX		46. Specific NAICS Code (6 digit) XXXXXX		47. Texas Comptroller Taxpayer No. XXXX	
48. Workers' Compensation Insurance Company Texas A&M System Risk Management				49. Policy Number Self Insured			
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"/>							
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date - -							

