



Directions for Using First Report of Injury Form

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 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. Enter dates as MM/DD/YY (example: 01/17/18).

Important: Submission of Completed Form -

The Employers First Report of Injury or Illness Form is to be filled out by the employee's immediate supervisor or designee and faxed to Benefit Services at 979-862-3128 or emailed as an attachment to benefits@tamu.edu within 24 business hours of the department's knowledge of the incident.

1. Enter last name, first name, middle initial of ill or injured employee.
2. *Indicate if injured employee is male or female
3. For security purposes, enter only the last four digits of the employee's Social Security number (SSN). **Note:** Any portion of the employee's Universal Identification Number is not sufficient for WCI purposes. You may leave this box blank if you are having difficulty obtaining the claimant's SSN.
4. Enter phone number where employee may be contacted, including area code.
5. Enter birth date.
6. Indicate if the employee speaks English. If the employee speaks another language, indicate the language.
7. *Indicate the employee's race.
8. *Indicate the employee's ethnicity.
9. Enter current mailing address (please include zip code).
10. Indicate marital status.
- 11.-14. Information preferred, but may be left blank if unknown.
15. Indicate date of injury. This date should be the actual date of injury, or, for occupational diseases, the date should be the date the employee knew or should have known the condition was work-related.
16. Indicate time of injury and AM or PM.
17. Indicate date lost time began (not including date of injury) or indicate no lost time as "NLT"
18. Use the **drop-down box** to indicate the nature of injury (strain, laceration, contusion, etc.) or type of exposure (radiation, chemical, etc.), or if occupational illness. **Note:** If you wish to print the document, you may move the drop-down box to the period "." to have room to write. *Please contact Benefit Services at the number or email address below if you find that an item needs to be added to our drop-down boxes.*
19. Use the **drop-down box** to indicate the body part involved in injury (foot, mouth, back, etc.). An additional free-text box is available to use for multiple injuries or a body part not noted in the drop-down box. **Note:** If you wish to print the document, you may move the drop-down box to the period "." to have room to write. *Please contact Benefit Services at the number or email address below if you find that an item needs to be added to our drop-down boxes.*
20. Provide brief but specific description of how injury occurred.

21. Indicate if the employee was working within the course and scope of their position description.
22. Indicate work location (dock area, kitchen area, outside area, parking area, etc.).
23. List name of department.
24. Indicate the cause of injury or exposure (slippery floor, machinery malfunction, contact with chemical, etc).
25. List only witnesses who have first-hand knowledge of the injury or illness.
26. Indicate date employee returned to work or is expected to return to work, if known.
27. Indicate if the employee died from the injury or illness. If yes, then notify Benefit Services at (979) 862-1718 immediately.
28. Provide name of employee's immediate supervisor.
29. Enter date injury was reported.
30. Enter employee date of hire.
31. Indicate if employee was hired in Texas.
32. Enter length of service in current position.
33. Determine the employee's total length of time in the occupation, including length of service with The Texas A&M University System and outside employers.
34. Enter employee's 4-digit job classification code.
35. Enter employee's job title number.
36. Enter employee current rate of pay by hour and by week.
37. Enter hours worked each week (40 hours at 5 days or 20 hours at 5 days, etc.)
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.
39. Indicate "No".
40. Enter name of Departmental HR liaison. NOTE: Injured employees may not complete this form.
41. Enter Texas A&M University
42. Enter departmental address and phone number
43. Enter TAMU Human Resources (1255 TAMU, College Station, Texas 77843-1255).
44. Enter TAMU Tax ID # 74-6000-531.
- 45.-47. Leave blank.
48. Enter The Texas A&M University System – Self-Insurance (Carrier).
49. Enter Self-insured.
50. Leave blank.
51. Enter signature of person completing form.
52. Enter date the signature was completed.

**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.

NEED HELP?

Benefit Services

Phone (979) 862-1718 | Fax 979-862-3128

benefits@tamu.edu