TDI Division of Workers' Compensation

| Complete if known: |
|---|
| DWC claim # |
| Insurance carrier claim # |

# Employer's first report of injury or illness

## Part 1: Injured employee information

| 1. **Name** (first, middle, last) | | 2. **Address** (street or PO box, city, state, ZIP code) | |
|---|---|---|---|
| 3. **Phone number** | 4. **Email address** | 5. **Social Security number** (XXX-XX-XXXX) | 6. **Date of birth** (mm/dd/yyyy) |
| 7. **Marital status** | | 8. **Sex** ☐ Female ☐ Male ☐ Other | |
| 9. **Spouse's name** (first, middle, last) | | 10. **Number of dependent children** | |
| 11. **Does the employee speak English?** ☐ Yes ☐ No **If no, specify language** | | | |
| 12. **Doctor's name** (first, last) | | 13. **Doctor's mailing address** (street or PO box, city, state, ZIP code) | |

## Part 2: Injury information

| 14. **Date of injury or illness** (mm/dd/yyyy) | 15. **Time of injury** : ☐ a.m. or ☐ p.m. | 16. **First day absent from work** (mm/dd/yyyy) |
|---|---|---|
| 17. **Supervisor's name** (first, last) | | 18. **Date injury reported** (mm/dd/yyyy) |
| 19. **Nature of injury or illness** (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.) | | 20. **Body parts affected** |
| 21. **Describe in detail how and why the injury, illness, or death occurred** (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.) | | |
| 22. **Reported cause of injury** (Examples: overexertion due to lifting or pushing, slip, trip, fall.) | | |
| 23. **Was the employee doing their regular job?** ☐ Yes ☐ No | | |
| 24. **Address and name of the location where the injury, exposure, or death occurred** (business name, street or PO box, city, state, ZIP code) | | |
| 25. **List all witnesses** (first, last names) | | |



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**26. Number of days absent from work, not including the day of injury or the day of return to work**

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

| **27. Return-to-work date** (mm/dd/yyyy) ☐ Actual date or ☐ Expected date | **28. Did the employee die?** ☐ Yes ☐ No<br>If yes, provide the date of death. (mm/dd/yyyy) |
|---|---|

## Part 3: Employment information

| **29. Date of hire** (mm/dd/yyyy) | | **30. Occupation of injured employee** |
|---|---|---|
| **31. Length of service in current position**<br>Years Months | | **32. Length of service in current occupation**<br>Years Months |
| **33. Employee payroll classification code** | | **34. Was the employee hired or recruited in Texas?** ☐ Yes ☐ No |
| **35. Rate of pay at this job**<br>$ Hourly $ Weekly | **36. Full work week is**<br>Hours Days | **37. Last paycheck was**<br>$ for Hours or Days |

**38. Is the employee an owner, partner, or corporate officer?** ☐ Yes ☐ No

## Part 4: Employer information

| **39. Name and title of person completing form** (first, middle, last, title) | **40. Business name** | |
|---|---|---|
| **41. Business mailing address** (street or PO box, city, state, ZIP code) | **42. Phone number** | **43. Email address** |
| **44. Business location** (if different from mailing address) | **45. Federal employer identification number** | |
| **46. Primary North American Industry Classification System (NAICS) code** (six digits) | **47. Specific NAICS code** (six digits) | **48. Texas comptroller taxpayer number** |
| **49. Workers' compensation insurance carrier** | **50. Policy number** | |

**51. Did you request accident prevention services in the past 12 months?** ☐ Yes ☐ No

**If yes, did you receive them?** ☐ Yes ☐ No

## Part 5: Certification

**52. Certify with your signature:**

I certify the information in this form is true and correct.

**Signature**_____ **Date**_____

# FAQ
# Employer's first report of injury or illness

**Who do I send this form to?**
Send this form to your workers' compensation insurance carrier and to the injured employee or the injured employee's representative. Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC), unless DWC specifically requests it.

**When do I need to send this form?**
You must send the DWC Form-001 within eight days after:

1. The employee's first day of absence from work due to the injury;
2. You receive notice of occupational disease; or
3. An employee dies.

**Why do I need to send this form?**
Employers must file this form so the insurance carrier has the information they need to begin the claims process. You may be fined if you fail to send this report without having a good reason (good cause.)

**How should I send this form?**
You can file the form with the insurance carrier and send it to the injured employee or the injured employee's representative by email, fax, U.S. Postal Service, or personal delivery.

**Do I need to keep a copy of this form?**
Yes, you should keep a copy of this form to serve as the Employer's Record of Injury required by Texas Labor Code Section 409.006. For more requirements refer to DWC rule 120.2, *Employer's first report of injury and notice of injured employee rights and responsibilities.*

**Questions?**
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

**Note:** With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.