

Mail this form to:  
 OFFICE OF THE ATTORNEY GENERAL  
 Workers' Compensation Division  
 P.O. Box 13777  
 Austin, Texas 78711

TWCC CLAIM # \_\_\_\_\_

DIRECTOR'S # \_\_\_\_\_

Please read instruction sheet CAREFULLY,  
 giving special attention to items marked  
 with an asterisk (\*).

**EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS**

1. Name		2. Sex <input type="checkbox"/> F <input type="checkbox"/> M	
3. Social Security Number	4. Home Phone	5. Date of Birth	
6. Does the Employee Speak English? If no, Specify Language <input type="checkbox"/> YES <input type="checkbox"/> NO			
7. Mailing Address Street or P.O. Box			
8. City	State	Zip Code	9. County
10. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> 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	16. Time of Injury <input type="checkbox"/> am <input type="checkbox"/> pm	17. Date Lost Time Began	
18. Nature of Injury *		19. Part of Body Injured or Exposed *	
20. How and Why Accident/Injury Occurred *			
21. Was employee doing his regular job? <input type="checkbox"/> YES <input type="checkbox"/> 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 work date/or expected	27. Did employee die? <input type="checkbox"/> YES <input type="checkbox"/> NO	28. Supervisor's Name	29. Date Reported

30. Date of Hire	31. Was employee hired or recruited in Texas? <input type="checkbox"/> YES <input type="checkbox"/> NO	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. State Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this job _____ Hourly _____ Weekly _____ Monthly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was _____	39. Is employee an Owner, Partner, or Corporate Officer? <input type="checkbox"/> YES <input type="checkbox"/> NO

40. Name and Title of Person Completing Form Claim Coordinator		41. Name of Agency Sam Houston State University	
42. Agency Mailing Address and Telephone Number Street or P.O. Box Telephone P.O. Box 2356 936-294-1872		43. Agency Location Code 100/753/000 Name of Location: Sam Houston State University	
City Huntsville State TX Zip Code 77341-2356			
44. Federal Tax Identification Number 746001430	45. Primary Standard Industrial Classification Code (SIC)* 8221	46. Specific SIC Code* 8221	47. Comptroller Agency Code 753
48. Workers' Compensation Insurance Company State Employee's Division, Attorney General's Office		49. Policy Number TXSTATEPOL001	
50. Did you request accident prevention services in the past 12 ? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, did you receive them? <input type="checkbox"/> YES <input type="checkbox"/> NO		52. Number of Hours of Sick Leave Credited to Employee on Date of Injury	
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)  X _____ Claim Coordinator Date _____			



