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

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

TWCC CLAIM # _____

DIRECTOR'S # _____

# EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

| | | |
|---|---|---|
| 1. Name | | 2. Sex ☐ F ☐ M |
| 3. Social Security Number | 4. Home Phone | 5. Date of Birth |
| 6. Does the Employee Speak English? If no, Specify Language ☐ YES ☐ NO | | |
| 7. Mailing Address Street or P.O. Box | | |
| 8. City State Zip Code 9. County | | |
| 10. Marital Status ☐ Married ☐ Widowed ☐ Seperated ☐ 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 | 16. Time of Injury ☐ am ☐ 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? ☐ 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 work date/or expected | 27. Did employee die? ☐ YES ☐ NO | 28. Supervisor's Name | 29. Date Reported |

| | | | |
|---|---|---|---|
| 30. Date of Hire | 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. 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? ☐ YES ☐ N |

| | | | |
|---|---|---|---|
| 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: P.O. Box 2356 Telephone: 936-294-1872 | | 43. Agency Location Code: 100/753/000 | |
| City: Huntsville State: TX Zip Code: 77341-2356 | | Name of Location: Sam Houston State University | |
| 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 ? ☐ **YES** ☐ N If yes, did you receive them? ☐ **YES** ☐ N | | 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 _____ | | | |

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