Instructions for Completing Employer’s First Report of Injury Form

The Employer’s First Report of Injury or Illness Form (DWC Form-1) is not a Texas A&M Health Science Center 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 Employer’s 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. Where dates are required enter MM/DD/YY (example: 01/17/07).

Important: Submission of Completed Form
The Employer’s First Report of Injury or Illness Form is to be filled out by the employee’s immediate supervisor or designee and emailed as an attachment to hsc-workerscomp@tamhsc.edu within 24 hours of the department’s knowledge of the incident.

Section 1 – Employee Information
1. Enter last name, first name, middle initial of ill or injured employee.
2. *Indicate if injured employee is female or male.
3. Enter the employee’s Social Security Number (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.

Section 2 – Injury Information
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. Indicate the nature of injury (strain, laceration, contusion, etc.) or type of exposure (radiation, chemical, etc.), or if occupational illness.
19. Indicate the body part involved in injury (foot, mouth, back, etc.).
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 location where injury occurred (dock area, kitchen area, classroom, outside area, parking area, etc.).
23. The exact street address where the injury occurred – as close as possible. If a business site, provide the name of department/business.
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. Note: We may ask for statements from these witnesses.
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 HSC Risk Management at (979) 436-9250 immediately.
28. Provide name of employee’s immediate supervisor.
29. Enter date injury was reported.

Section 3 – Employee Pay Information
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.
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”.

Section 4 – Component/Department Information
40. Enter full name and title of Component/Departmental (HR Liaison). *This cannot be the injured employee.*
41. Enter Texas A&M Health Science Center
42. Enter Component/Departmental address and phone number
43. Enter TAMHSC Risk Management (200 Technology Way, Suite 2079, College Station, Texas 77845-3424)
44. Enter TAMHSC Tax ID #: 74-2907553
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 or person completing form and date of completion. *This cannot be the injured employee.*

* 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.*