Accident Report

Name of person making report_____

Injured person_____

Age of injured_____ Time of injury_____

Place of accident_____

Equipment involved_____

Nature of injury_____

_____

Treatment given: First Aid_____

_____

Other treatment_____

_____

Person (parent or other) notified_____

Attending Physician's name_____

What was person doing when accident occurred?_____

_____

_____

Names of witnesses_____

_____

What were the contributing factors to the accident?_____

_____

_____

What corrective action is being taken to alleviate conditions leading to the accident? ___

_____

_____

_____

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? If No, Specify Language YES ☐ NO ☐		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐	
9. Mailing Address Street or P.O. Box		
City	State	Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ 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 (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*	19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness 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 (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name / 29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	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. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____ for ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )		43. Business Location (If different from mailing address) Number and Street	
City	State Zip Code	City	State Zip Code
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____