## DWC FORM-1 (Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

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.

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 filing.

[Workers' Compensation Rule 120.2]



## INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. 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 filing.

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed \$500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. 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 filing. The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

## "SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race,
	ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.

Item 4:	If no home phone	please provide a	phone number where t	the employee can be reached.

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Items	ວ. ີ	ID.	17.

26,29,30: Enter data in month, day, year format. Example: 08-13-54.

Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.

Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.

Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot,

etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.

Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Items 32,33: Enter date in month-year format. Example: 02-56.

Item 37: Enter the number of days or hours that make up a full work week for your employees.

Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code

which appears in block 5 of Form C-3, "Émployer's Quarterly Report" to the Texas Workforce Commission.

Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple

NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in

at the time of the injury. This may or may not be the same as the primary code.



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, CLAIM# Unless the Division specifically requests a direct filling. **CARRIER'S CLAIM# EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS** 2. Sex <sub>F</sub>□ <sub>M</sub>□ 1. Name (Last, First, M.I.) 15. Date of Injury (m-d-y) 16. Time of Injury 17. Date Lost Time Began (m-d-y) am pm pm 4. Home Phone 5. Date of Birth (m-d-y) 3. Social Security Number 18. Nature of Injury\* 19. Part of Body Injured or Exposed\* 6. Does the Employee Speak English? If No, Specify Language 20. How and Why Injury/Illness Occurred\* YES NO NO 21. Was employee doing his YES 7. Race 22. Worksite Location of Injury (stairs, dock, etc.)\* 8. Ethnicity Hispanic 🗌 White regular job? NO Asian  $\square$ Black Native American Other 23. Address Where Injury or Exposure Occurred Name of business if incident 9. Mailing Address Street or P.O. Box occurred on a business site City State Zip Code County Street or P.O. Box County 10. Marital Status Zip Code Married Widowed Separated Single U Divorced  $\square$ 11. Number of Dependent Children 12. Spouse's Name 24. Cause of Injury(fall, tool, machine, etc.)\* 13. Doctor's Name 25. List Witnesses

14. Doctor's Mailing Address (Stre	26. Return to we date/or expect (m-d-y)		28. Supervisor's Name	29. Date Reported (m-d-y)		
City	State Zip	) Code		YES NO		
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30. Date of Hire (m-d-y)	of Hire (m-d-y)  31. Was employee hired or recruited in Texas?		32. Length of Service in Current Position		33. Length of Service in Occupation	
	YES NO		Months	Years	Months	Years
34. Employee Payroll Classification	on Code	35. Occupation of Injured V	Vorker			
36. Rate of Pay at this Job 37. Full Work Week is:			38. Last Paycheck was:		39. Is employee an Owner, Partner, or Corporate Officer?	
\$Hourly \$Weekly	Hours	Days	\$ for	Hours or Days	YES	
40. Name and Title of Person Con	mpleting Form		41. Name of Bu	siness		
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 C	Code
44. Federal Tax Identification Number  45. Primary North American Industry Class Code: (6 digit)			cation System	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.	
48. Workers' Compensation Insurance Company			49. Policy Number			
50. Did you request accident prev	vention services in past 12	months?	•			
YES NO	If yes, did you receive	them? YES NO				
51. Signature and Title (READ IN	STRUCTIONS ON INSTR	UCTION SHEET BEFORE SI	GNING)			
X				Date		

