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.**

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 XXX-XX-
4. Home Phone
5. Date of Birth (m-d-yyyy)
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* Select One
19. Part of Body Injured or Exposed* Select One
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-yy)

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 **Texas A&M University**
42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street **Texas A&M University Human Resources (1255 TAMU)**
City State Zip Code **College Station, TX 77843-1255**
44. Federal Tax Identification Number **74-6000-531**
45. Primary North American Industry Classifications System Code (6 digit) **XXXX**
46. Specific NAICS Code (6 digit) **XXXXXX**
47. Texas Comptroller Taxpayer No. **XXXX**
48. Workers' Compensation Insurance Company **Texas A&M System Risk Management**
49. Policy Number **Self Insured**
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