## 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 the employee	e can be reached.
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Items	'n	15	1/	

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, Unless the Division specifically requests a direct filling.

CLAIM#	 	 	

CARRIER'S CLAIM#	

	CARRIER'S CLAIM#							
	E	MPLOYER	RS FIRST REPOR	RT OF INJ	URY OF	RILLNES	S	
1. Name (Last, First, M.I.)				15. Date of Inju		16. Time of Inju	17. Date Lost Time Began	
			F-D M-D			: am [	¬ pm □   (	(m-d-y) 
Social Security Number			te of Birth (m-d-y)	18. Nature of In	njury*	19. Part of Boo	dy Injured or Ex	posed*
	( )							
6. Does the Employee Speak		f No, Specify Lang	uage	20. How and W	hy Injury/Illne	ess Occurred*		
YES NO								
7. Race White  Black  Asian  Black	1		spanic	21. Was employee doing his YES regular job? NO				
9. Mailing Address Street o			_ Other _		here Injury or a business s		red Name of bu	usiness if incident
City	State	Zip Cod	de County	Street or P.0	O. Box		County	
10. Marital Status  Married   Widowed	☐ Separa	ated D Single	□ Divorced □	City		State	Zip Co	ode
11. Number of Dependent Ch		12. Spouse's Na		24. Cause of Injury(fall, tool, machine, etc.)*				
13. Doctor's Name				25. List Witness	ses			
14. Doctor's Mailing Address (Street or P.O.Box)			26. Return to w date/or expec (m-d-y)	/or expected die? Na		28. Supervisor Name	29. Date Reported (m-d-y)	
City State Zip Code			Code		YE	s NO D		
	1						1 00 1 11	
30. Date of Hire (m-d-y)			d or recruited in Texas?	32. Length of Service in Current Position  33. Length of Service in Occupa			·	
34. Employee Payroll Classific		ES NO C	35. Occupation of Injured W	Months Years Months Years Months Years Months Years Months Years				
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36. Rate of Pay at this Job	37. F	ull Work Week is:		38. Last Paycheck was:  39. Is employee an Owner, Partner or Corporate Officer?				
\$Hourly \$Wee	ekly	Hours	Days	\$ for	r Hours	or Days	YES C	
40. Name and Title of Person	Completing	Form		41. Name of Bu	icinocc		•	
				41. Name of Bo	3311633			
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			Zip Code		
44. Federal Tax Identification Number  45. Primary North American Industry Classification Code: (6 digit)			sification System  46. Specific NAICS Code (6 digit)  47. Texas Comptroller Taxpayer N			omptroller Taxpayer No.		
48. Workers' Compensation Insurance Company  49.				49. Policy Num	ber		ı	
50. Did you request accident	prevention se	ervices in past 12 r	nonths?	1				
YES NO D	If yes	, did you receive th	nem? YES NO	NUNIO)				
51. Signature and Title (REAL	NSTRUCT	IONS ON INSTRU	ICTION SHEET BEFORE SIG	INING)	Date	٩		

