

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS (TWCC-1S)

Required:

This form must be completed and filed with the State Office of Risk Management (SORM) for any on-the-job injury that:

- Has more than one day of lost time;
- Is an occupational disease with or without lost time or medical expenditures;
- Results in expenses for medical treatment or service; or
- Resulted in the death of the employee.

It is important that every applicable box be completed. Incomplete or missing data often prevents efficient processing of the claim and can prevent the injured employee from receiving benefits in a timely manner.

Please note: If an on-the-job injury is not an occupational disease, does not result in medical treatment, does not result in the death of the employee or results in less than one day of lost time, the employer will retain the record on file only.

Filing Deadline:

This form must be received by SORM no later than the next working day after first notice of injury is reported to the employing agency. **This form must be given to the Claims Coordinator in Human Resource Services in time to meet the SORM deadline.**

Completed By:

The supervisor completes the form with assistance, if possible, from the injured employee.

Instructions:

PLEASE COMPLETE ALL APPLICABLE BOXES. Most are self-explanatory; however, the following may require more attention:

- 4: If the employee has no home phone, please give a phone number where the employee can be reached.
- 8: Leave blank.
- 13: This information should include the doctor's phone number.
- 17: This should be the first full day of lost time from work. The date of injury is not considered the first day of lost time.
- 18: Give the nature of the injury; e.g., burn, cut, sprain, etc.
- 19: List the specific body part injured, including side; e.g., chin, right leg, left upper arm, etc.
- 20: Describe in detail. Use an additional sheet if necessary.
- 24: This should state the specific substance or exposure that directly inflicted the injury, such as a tool, chemical, machine, etc.

- 28: This is the employee's immediate supervisor. Please include a work phone number.
- 29: This is the date the employee reported the injury to the employer as being work related.
- 32: This is the period of time the employee has been working in the current position.
- 33: This information should indicate how long the employee has worked in this type of job.

The Claims Coordinator will complete the remaining information on this form.

Mail this form to:
 STATE OFFICE OF RISK MANAGEMENT
 P. O. Box 13777
 Austin, Texas 78711

TWCC CLAIM # _____

SORM CLAIM # _____

Please read instruction sheet CAREFULLY,
 giving special attention to items marked
 with an asterisk (*).

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y)	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y)			
3. Social Security Number	4. Home Phone ()		5. Date of Birth (m-d-y)		18. Nature of Injury*		19. Part of Body Injured or Exposed*		
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>				20. How and Why Accident/Injury Occurred*					
7. Employee Telephone #		8. Block no longer used							
9. Mailing Address Street or P.O.Box				21. Was employee doing his/her regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*			
City	State	Zip Code	County		23. Address Where Injury or Exposure Occurred. Name of business if incident occurred on a business site.				
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>				Street or P.O. Box		County			
11. Number of Dependent Children		12. Spouse's Name						City State Zip Code	
13. Doctor's Name				Telephone #					
14. Doctor's Mailing Address (Street or P.O.Box)									
City	State	Zip Code		26. Return to work date (m-d-y)		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Years _____ Months _____	33. Length of Service in Occupation Years _____ Months _____
34. State Payroll Classification Code		35. Occupation of Injured Worker	
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly \$ _____ Monthly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: \$ _____	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

40. Name and Title of Person Completing Form Claims Coordinator		41. Name of Agency	
42. Agency Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Agency Location Code ____ / ____ / ____ Name of Location: _____	
City	State	Zip Code	
44. Federal Tax Identification Number	45. Primary Standard Industrial Classification Code (SIC)* (4 digit)	46. Specific SIC Code* (4 digit)	47. Comptroller Agency Code ____
48. Workers' Compensation Insurance Company State Office of Risk Management		49. Policy Number TXSTATEPOL001	
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>		52. Number of Hours of Sick/Annual Leave Credited to Employee on Date of Injury	
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)			

INSTRUCTIONS TO SUPERVISORS COMPLETING THE TIMESHEET FOR WORK-RELATED INJURIES OR ILLNESSES

The most recent workers' compensation legislation changed the way an injured state employee can use accrued sick leave and accrued annual leave before receiving income benefits. This change affects absences for all injuries or illnesses occurring **September 1, 1999 or later**.

- Please review the injured employee's timesheet carefully.
- Missed time from work due to a work-related injury or illness should reflect the employee's election with the notation "wc" and the number of hours absent. You may want to keep a copy of the Employee's Election Regarding Utilization of Sick and Annual Leave (SORM 80) for reference. An employee's election can not be changed when absences occur for a particular injury or illness.
- Absences for a work-related injury or illness may not necessarily be consecutive; however, all such absences must be recorded based on the employee's election.

If you have any questions about an employee's election or completion of the timesheet, please call Jimmie Wilson at extension 2693.