

# **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.
- 7 & 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							
City		State	Zip Code	County			
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>							
11. Number of Dependent Children			12. Spouse's Name				
13. Doctor's Name				Telephone #			
14. Doctor's Mailing Address (Street or P.O.Box)							
City		State	Zip Code				
21. Was employee doing his/her regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 (Name, Telephone #)							
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 <b>State Office of Risk Management</b>				49. Policy Number <b>TXSTATEPOL001</b>			
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.

## **SUPERVISOR'S INVESTIGATION OF EMPLOYEE'S ACCIDENT/INCIDENT**

### **Required:**

This form must be completed and forwarded to the Claims Coordinator.

### **Filing Deadline:**

This form must be sent to the Claims Coordinator no later than the next working day after first notice of injury is reported to the employing agency. If the form cannot be completed in time to send with the TWCC-1S, the form should be sent to the Claims Coordinator as soon as possible.

### **Completed By:**

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

### **Instructions:**

Please complete applicable information in each section on both the front and backsides of the form. **After completing the narrative in section "N," the form must be reviewed by the Department Safety Coordinator (Section P.1) and the department head (Section P.2). These two parts of Section P must be completed before the form is sent to the Claims Coordinator.**



**I. ACT/PRACTICE ASSOCIATED WITH OCCURRENCE (CHECK ONE ONLY)**

- 01 Contact with electrical source (tool, device, wire, etc.)
- 02 Entering an unauthorized area
- 03 Failure to practice safe driving technique
- 04 Failure to use established route or taking short cut
- 05 Failure to use handrail, grab bar
- 06 Failure to use lockout device
- 07 Failure to use/wear personal protective equipment (PPE)
- 08 Failure to warn of known hazards (i.e. no safety sign, light, barricade, instruction, etc.)
- 09 Failure to wear appropriate dress (shoes, shirt, blouse)
- 10 Handling (of object, material, item or thing)
- 11 Horseplay
- 12 Improper making or storing (non-compatible material, chemicals, etc.)
- 13 Improper placing or storing (materials, tools, equipment)
- 14 Lifting (including position, stance)
- 15 Making safety devices inoperative
- 16 No unsafe act/practice on part of injured
- 17 Operating/working at unsafe speed
- 18 Operating or unnecessary exposure to hazards (gas, fumes, dust, chemicals, mist, radiation)
- 19 Over or unnecessary exposure to hazards (gas, fumes, dust, chemicals, mist, radiation, etc.)
- 20 Repairing or servicing moving object/thing (machine, equipment, etc.)
- 21 Riding moving equipment not designed for passengers
- 22 Unobservant (daydreaming, inattentive, etc.)
- 23 Using unsafe/defective tool, material, equipment
- 24 Using wrong tool, material equipment
- 25 Working/walking under suspended load (crane, hoist, derrick)
- 26 Working in a confined space without proper safeguard
- 27 Working without adequate lighting
- 28 Other (specify) \_\_\_\_\_

**J. CONDITION (PHYSICAL HAZARD) ASSOCIATED WITH OCCURRENCE (CHECK ONE)**

- 01 Congested area
- 02 Electrical hazard (uninsulated wire, overloaded circuit, inadequate ground, etc.)
- 03 Excessive noise
- 04 Harmful animals/insects/reptiles
- 05 Health hazards (radiation, gas, fumes, dust, vapors, etc.)
- 06 Improper housekeeping
- 07 Improperly stored chemicals, hazardous substances
- 08 Inadequate ventilation
- 09 Inadequate or no warning signs
- 10 Layout or design (office, shop, equipment)
- 11 Lighting
- 12 Mislabelled/Unlabeled chemicals, hazardous materials, etc.
- 13 No unsafe condition
- 14 Open trench hole, ditch, sharp drop-off
- 15 Poisonous vegetation (oak, ivy, etc.)
- 16 Protruding object (nail, wire, splinter, etc.)
- 17 Rough/sharp objects
- 18 Slipping or tripping hazard
- 19 Steps, stairs, ladder, or other working surfaces
- 20 Unguarded machine, belt, pulley, roller, etc.
- 21 Unsafe/defective hand or electric tools
- 22 Unsafe equipment
- 23 Unsafe material
- 24 Unsafe vehicle
- 25 Unshored trench, excavation, etc.
- 26 Walkway, sidewalk, pavement
- 27 Other (specify) \_\_\_\_\_

**K. DID THE STATE OR UNIT HAVE A SAFETY RULE, REGULATION, OR STANDARD THAT WOULD HAVE PREVENTED THE OCCURRENCE?**

01 Yes                      02 No

**L. WAS THE RULE, REGULATION OR STANDARD VIOLATED?**

01 Yes                      02 No

**M. ACTION(S) TAKEN OR PLANNED TO PREVENT RECURRENCE (CHECK ALL THAT APPLY)**

- 01 Action taken with employee for violating rules, regulations or procedures
- 02 All employees were made aware of the occurrence cause, consequence, and action taken to prevent recurrence
- 03 Injured person given basic training
- 04 Employee given refresher or remedial training
- 05 Existing rule, regulation or standard (SOP) enforced
- 06 Existing rule, regulation or standard (SOP) revised
- 07 New rule, regulation or standard prepared
- 08 Physical hazards corrected
- 09 Other positive action taken (specify) \_\_\_\_\_

**N. DESCRIBE BRIEFLY IN NARRATIVE FORM THE CIRCUMSTANCES THAT LED TO AND CAUSED THIS OCCURRENCE. ANSWER: WHO, WHAT, WHERE, WHEN AND HOW? (USE ADDITIONAL PAGE IF NEEDED)**

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INJURED'S IMMEDIATE SUPERVISOR (PRINT)	SIGNATURE	DATE	PHONE

P. REVIEWED BY	<b>P.1 SECTION/DEPARTMENT ADDITIONAL DUTY SAFETY OFFICER COMMENT:</b>		
	SIGNATURE:		DATE:
	<b>P.2 SECTION/DEPARTMENT/DIVISION HEAD COMMENT:</b>		
	SIGNATURE:		DATE:
<b>P.3 AGENCY OR FACILITY SAFETY MANAGER</b>			
A) Repeat occurrence:    01 No    02 Yes; total incidents    03 Two    04 Three    05 Four    06 Five    07 Over five			
B) Were more than two (2) workers injured in this accident? (If so, complete a separate form for each injured)    01 Yes    02 No			
C) Comment:			
SIGNATURE:		DATE:	