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

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

**TWCC CLAIM # __________________________**

**SORM CLAIM # __________________________**

**EMPLOYER’S FIRST REPORT OF INJURY OR ILLNESS**

1. Name (Last, First, M.I.)  
2. Sex  
   - F  
   - M  

3. Social Security Number  
4. Home Phone ( )  
5. Date of Birth (m-d-y)  

6. Does the Employee Speak English?  
   - YES  
   - NO  

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  
   - Widowed  
   - Separated  
   - Single  
   - Divorced  

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  

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*  
19. Part of Body Injured or Exposed*  

20. How and Why Accident/Injury Occurred*  

21. Was employee doing his/her 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 (Name, Telephone #)  

26. Return to work date (m-d-y)  
27. Did employee die?  
   - YES  
   - NO  

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  
   - NO  

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  
   - NO  

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 ( )  
City  
State  
Zip Code  

43. Agency Location Code  
   ___ ___ / ___ ___ / ___ ___  
Name of Location:  

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  
   - NO  
   - If yes, did you receive them?  
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.