TDI Division of Workers' Compensation

Complete if known:
DWC claim #
SORM claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)	**2. Address** (street or PO box, city, state, ZIP code)		
3. Phone number	**4. Email address**	**5. Social Security number** (XXX-XX-XXXX)	**6. Date of birth** (mm/dd/yyyy)
7. Marital status	**8. Sex** ☐ Female ☐ Male ☐ Unknown		
9. Spouse's name (first, middle, last)		**10. Number of dependent children**	
11. Does the employee speak English? ☐ Yes ☐ No **If no, specify language**			
12. Doctor's name (first, last)	**13. Phone number**	**14. Mailing address** (street or PO box, city, state, ZIP code)	

Part 2: Injury information

15. Date of injury or illness (mm/dd/yyyy)	**16. Time of injury** : ☐ a.m. or ☐ p.m.	**17. First day absent from work** (mm/dd/yyyy)
18. Supervisor's name (first, last)		**19. Date injury reported** (mm/dd/yyyy)
20. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		**21. Body parts affected**
22. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)		
23. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)		
24. Was the employee doing their regular job? ☐ Yes ☐ No		
25. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)		
26. List all witnesses (first, last names)		

27. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

28. Return-to-work date (mm/dd/yyyy) ☐ Actual date or ☐ Expected date	**29. Did the employee die?** ☐ Yes ☐ No If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

30. Date of hire (mm/dd/yyyy)	**31. Occupation of injured employee**
32. Length of service in current position Years Months	**33. Length of service in current occupation** Years Months
34. State payroll classification code	**35. Was the employee hired or recruited in Texas?** ☐ Yes ☐ No

36. Rate of pay at this job	**37. Full work week is**	**38. Last paycheck was**
$ Hourly Weekly $ Monthly	Hours Days	$ for Hours or Days

39. Number of sick/annual leave hours credited to employee for date of injury:

Part 4: Employer information

40. Name and title of person completing form (first, middle, last, title)	**41. Agency name**	
42. Agency mailing address (street or PO box, city, state, ZIP code)	**43. Phone number**	**44. Email address**
45. Agency location code (###/###/###) **and location name**	**46. Federal employer identification number**	
47. Primary North American Industry Classification System (NAICS) code (six digits)	**48. Specific NAICS code** (six digits)	**49. Texas comptroller agency code**
50. Workers' compensation insurance carrier **State Office of Risk Management**	**51. Policy number** **TXSTATEPOL001**	

52. Did you request accident prevention services in the past 12 months? ☐ Yes ☐ No
If yes, did you receive them? ☐ Yes ☐ No

Part 5: Certification

53. Certify with your signature:

I certify the information in this form is true and correct.

Signature_____ **Date**_____

FAQ
Employer's first report of injury or illness

Who do I send this form to?
Send this form to the State Office of Risk Management (SORM) and to the injured employee or the injured employee's representative. Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC), unless DWC specifically requests it.

When do I need to send this form?
You must send the DWC Form-001S within eight days after:

1. The employee's first day of absence from work due to the injury;
2. You receive notice of occupational disease; or
3. An employee dies.

Why do I need to send this form?
Employers must file this form so SORM has the information they need to begin the claims process. You may be fined if you fail to send this report without having a good reason (good cause.)

How should I send this form?
You can file the form with SORM and send it to the injured employee or the injured employee's representative by email, fax, U.S. Postal Service, or personal delivery.

State Office of Risk Management
P.O. Box 13777
Austin, Texas 78711
Fax#: 512-370-9025

Do I need to keep a copy of this form?
Yes, you should keep a copy of this form to serve as the Employer's Record of Injury required by Texas Labor Code Section 409.006. For more requirements refer to 28 Texas Administrative Code Section 120.2, *Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities*.

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.