

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.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS 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 Injury/Illness Occurred*					
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*			
9. Mailing Address Street or P.O. Box City State Zip Code County				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					
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>				24. Cause of Injury(fall, tool, machine, etc.)*					
11. Number of Dependent Children		12. Spouse's Name		25. List Witnesses					
13. Doctor's Name				26. Return to work date/or expected (m-d-y)					
14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code				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 Months _____ Years _____		33. Length of Service in Occupation Months _____ Years _____	
34. Employee Payroll Classification Code		35. Occupation of Injured Worker					
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly		37. Full Work Week is: _____ Hours _____ Days		38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>	

40. Name and Title of Person Completing Form				41. Name of Business Marlin ISD			
42. Business Mailing Address and Telephone Number Street or P.O. Box 130 Coleman St. City State Zip Code Marlin Tx 76661				43. Business Location (If different from mailing address) Number and Street City State Zip Code			
44. Federal Tax Identification Number 174660016987		45. Primary North American Industry Classification System Code (6 digit) 611110		46. Specific NAICS Code (6 digit) 611110		47. Texas Comptroller Taxpayer No. N/A	
48. Workers' Compensation Insurance Company WC Solution				49. Policy Number WC 00840			
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"/>							
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____							

