Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier 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. Social Security number** (XXX-XX-XXXX)	**5. Date of birth** (mm/dd/yyyy)
6. Marital status	**7. Sex** ☐ Female ☐ Male ☐ Other	
8. Spouse's name (first, middle, last)	**9. Number of dependent children**	
10. Does the employee speak English? ☐ Yes ☐ No **If no, specify language**		
11. Race and ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (Specify if different from choices listed.)		
12. Doctor's name (first, last)	**13. Doctor's mailing address** (street or PO box, city, state, ZIP code)	

Part 2: Injury information

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

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25. List all witnesses (first, last names)

26. 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

27. Return-to-work date (mm/dd/yyyy)

☐ Actual date or ☐ Expected date

28. Did the employee die? ☐ Yes ☐ No

If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)

30. Occupation of injured employee

31. Length of service in current position

Years Months

32. Length of service in current occupation

Years Months

33. Employee payroll classification code

34. Was the employee hired or recruited in Texas?

☐ Yes ☐ No

35. Rate of pay at this job

$ Hourly $ Weekly

36. Full work week is

Hours Days

37. Last paycheck was

$ for Hours or Days

38. Is the employee an owner, partner, or corporate officer? ☐ Yes ☐ No

Part 4: Employer information

39. Name and title of person completing form (first, middle, last, title)

40. Business name

41. Business mailing address (street or PO box, city, state, ZIP code)

42. Phone number

43. Business location (if different from mailing address)

44. Federal employer identification number

45. Primary North American Industry Classification System (NAICS) code (six digits)

46. Specific NAICS code (six digits)

47. Texas comptroller taxpayer number

48. Workers' compensation insurance carrier

49. Policy number

50. Did you request accident prevention services in the past 12 months? ☐ Yes ☐ No

If yes, did you receive them? ☐ Yes ☐ No

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Part 5: Certification

51. Certify with your signature:

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

Signature____ **Date**____________________________

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FAQ
Employer's first report of injury or illness

Who do I send this form to?
Send this form to your workers' compensation insurance carrier 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-001 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 to provide the insurance carrier information necessary to begin the claims process. You may be fined if you fail to send this report without good cause.

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

Do I need to keep a copy of this form?
Yes, you should maintain a copy of this form to serve as the Employer's Record of Injury required by Section 409.006.

Questions?
Call 1-800-252-7031, 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.

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