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 (*).

CLAIM # _____

SORM CLAIM # _____

EMPLOYERS 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? If No, Specify Language
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 North American Industrial Classification System Sector Code (NAICS) (2 digits)

46. Specific NAICS Code

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? YES ☐ NO ☐

52. Number of Hours of Sick/Annual Leave Credted to Employee or Date of Injury

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

DWC FORM-1S Instructions

PLEASE COMPLETE ALL APPLICABLE FIELDS. Most fields are self-explanatory; however, the following items may require more attention:

Item 4: If no home phone, please give a phone number where the employee can be reached.
Item 7: Employees work phone number.
Item 8: This information is no longer required.
Item 13: This information should include the doctor's telephone number.
Item 15: This should be the actual date of injury, or (for occupational diseases) the date the employee knew or should have known the condition was work-related.
Item 17: This should be the first full day of lost-time from work. (Please note that the date of injury is not considered the first day of lost time.) Mark NLT or N/A if there is no lost time.
Item 18: List the nature of the injury. Examples include: burn, cut, or sprain.
Item 19: List specific body part, which side of body is affected, e.g., chin, **right** leg, **left upper** arm, etc. If more than one body part is affected, list each part.
Item 20: Describe in detail. Use additional sheet of paper if necessary.
Item 24: This should state the specific substance or exposure that directly inflicted the injury such as a tool, chemical (list the name of the chemical), or machine.
Item 26: The date should be entered even if the employee has returned to work even for a portion of the day. If the employee has returned to work making less than his or her pre-injury wage, a DWC FORM-6 must also be submitted.
Item 28: This is the employee's immediate supervisor. Please include a work telephone number.
Item 29: This is the date the employee reported the injury to the employer as work related.
Item 34: This 4-digit code corresponds to the primary occupation in which the employee was engaged at the time of the injury or exposure. This code is from the state payroll classification table and is available from the State Comptroller of Public Accounts.
Item 43: This 9-digit code represents the location of the agency unit that employed the injured worker at the time of their injury or exposure. The first three digits will be 100 for state agencies or 200 for county entities. The second three digits are the agency code. The third three digits are the location code as established by each agency. Contact the SORM's Risk Assessment and Loss Prevention section for information about or changes to your agency location code(s).
Item 44: This 9-digit code is assigned to each agency by the Internal Revenue Service for employment, tax, and reporting purposes.
Item 45: This 2-digit code is assigned to each agency according to its primary business activity. For specific questions regarding your NAICS code, call your local Texas Workforce Commission (TWC).
Item 46: This is a 3- or 4-digit code for the specific subsector of the business activity of the agency.
Item 47: This is the state agency code number assigned by the State Comptroller of Public Accounts.
Item 51: This must be the signature and title of the claims coordinator. If signed by someone other than the claims coordinator, he or she must list his or her title and state that it was signed for the claims coordinator. The date must also be included.
Item 52: Enter the number of sick/annual leave hours credited to the employee as of the date of injury.

Distribution:
Fax a copy **or** mail the original to:
State Office of Risk Management
Mail a copy to the claimant.
Retain a copy for your file.

State Office of Risk Management
P.O. Box 13777
Austin, TX 78711-3777