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 filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number XXX - XX-	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? YES ☐ NO ☐ If No, Specify Language			20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
City	State	Zip Code County	Street or P.O. Box	County Val Verde	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City Del Rio	State TX	Zip Code 78840
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box)			26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name / 29. Date Reported (m-d-y) - -
City	State	Zip Code			

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☑ NO ☐	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 ☐ NO ☑

40. Name and Title of Person Completing Form		41. Name of Business San Felipe Del Rio CISD	
42. Business Mailing Address and Telephone Number Street or P.O. Box P.O. Drawer 428002	Telephone (830) 778-4000	43. Business Location (If different from mailing address) Number and Street	
City Del Rio	State TX / Zip Code 78842	City	State / Zip Code
44. Federal Tax Identification Number 741694073	45. Primary North American Industry Classification System Code: (6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
48. Workers' Compensation Insurance Company Texas Mutual Insurance Co.		49. Policy Number 0002132420	

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

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

X _____ Date _____