

**Form TWCC-1  
(Employer's First Report of Injury or Illness)**

The **employer** is required to file an **Employer's First Report of Injury or Illness** [Form TWCC-1 (Rev. 7/04)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. **\*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

*[Texas Workers' Compensation Commission Rule 120.2]*



## INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (TWCC-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (Form TWCC - 1 (Rev. 7-04)) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. **\*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed \$500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. **\*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.** The Commission's Health and Safety Division will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Commission or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

### "SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

- Items 2,7,8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Commission to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.
- Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
- Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
- Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
- Items 32,33: Enter date in month-year format. Example: 02-56.
- Item 37: Enter the number of days or hours that make up a full work week for your employees.
- Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
- Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.



Send the specified copies to your  
Workers' Compensation Insurance Carrier  
and the injured employee.

\*Employers - Do not send this form to the  
Texas Workers' Compensation Commission, unless  
the Commission specifically requests a direct filing.

TWCC CLAIM # _____
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CARRIER'S CLAIM # _____
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### EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex <input type="checkbox"/> F <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box			
City	State	Zip Code	County
10. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children	12. Spouse's Name		
13. Doctor's Name			
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 <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y)	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		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			
26. Return to work date/or expected (m-d-y)	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 _____
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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	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )		43. Business Location (If different from mailing address) Number and Street	
City	State	Zip Code	City State Zip Code

44. Federal Tax Identification Number	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		49. Policy Number	

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"/>	
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51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) <b>X</b> _____ Date _____
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**EMPLOYEE'S REPORT OF ACCIDENT**

**Campus/ Location of Accident:** \_\_\_\_\_

**Name of Injured Employee:** \_\_\_\_\_

**Position:** \_\_\_\_\_ **Department:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Place Where Accident Occurred:** ( ) Classroom ( ) Hall ( ) Cafeteria  
( ) Other: \_\_\_\_\_

**Description of Accident:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe Injury: (Part of Body Affected)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How Could Accident Have Been Prevented:** \_\_\_\_\_  
\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

RETURN THIS FORM TO SUPERVISOR WITHIN 24 HOURS OF YOUR ACCIDENT.  
COPIES: PAYROLL OFFICE / INSURANCE CLERK AT MPC

**WITNESS STATEMENT**

Injured Employee's Name: \_\_\_\_\_

Injured Employee's Employer: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness Complete Address: \_\_\_\_\_  
\_\_\_\_\_

Witness Employer Name, Address, & Phone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I should move or change my address, I can be located through: \_\_\_\_\_  
Who resides at: \_\_\_\_\_  
\_\_\_\_\_

Name of Injured Employee: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_

Place Where Accident Occurred: ( ) Classroom ( ) Hall ( ) Cafeteria  
( ) Other: \_\_\_\_\_

Fully explain what you know about this accident: \_\_\_\_\_  
\_\_\_\_\_

Did you actually see this accident happen? \_\_\_\_\_

If not, how did you learn about it? \_\_\_\_\_

Describe Injury (part of body affected): \_\_\_\_\_

How could accident have been prevented? \_\_\_\_\_  
\_\_\_\_\_

Did this employee ever talk to you about getting hurt on the job? \_\_\_\_\_

If so, how soon after the accident did this conversation take place? \_\_\_\_\_

Do you know of any other injury, accident or illness that this employee has had? \_\_\_\_\_

If so, explain: \_\_\_\_\_

Has this employee worked since date of accident? \_\_\_\_\_

If so, did he appear able to work as hard as before the accident? \_\_\_\_\_

If not, explain: \_\_\_\_\_

How long have you known this employee? \_\_\_\_\_

Are you related to this employee? \_\_\_\_\_

If so, what is your relationship? \_\_\_\_\_

Please give the name and address of any other persons who might know anything about this accident:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NURSE'S REPORT OF ACCIDENT**

**Campus / Location of Accident:** \_\_\_\_\_

**Employee Name:** \_\_\_\_\_

**Position:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Time:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Date: of Accident:** \_\_\_\_\_

**Time of Accident:** \_\_\_\_\_

**Vital Signs: B.P.** \_\_\_\_ / \_\_\_\_ **Temperature:** \_\_\_\_\_ **Pulse:** \_\_\_\_\_

**Description of Injury:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Describe First Aid Administered:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Did Employee Require Further Medical Attention?** ( ) Yes ( ) No

**If so, What Doctor or Hospital?** \_\_\_\_\_

\_\_\_\_\_

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Nurses Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Copies: 1 -Your File

1 - Payroll Office/Insurance Clerk at MPC

**SUPERVISOR'S INCIDENT REPORT**

**Full Name of Employee Involved / Injured:** \_\_\_\_\_

**Date of Incident:** \_\_\_\_\_ **Time of Incident:** \_\_\_\_\_

**Exact Location of Incident:** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Job Site:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_

**Was Physician Contact Necessary?** ( ) Yes ( ) No

**If yes, Date of Notification:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Incident Facts:** Describe as accurately as possible what happened (i.e. if an injury resulted, state part of body injured and nature of injury)

**Statement of Involved/Injured Employee's Supervisor:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Were there witnesses?** ( ) Yes ( ) No

**If yes, list below:**

**Name:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Department:** \_\_\_\_\_ **Department:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Final Disposition: Include Description of Action Taken.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Signature of Supervisor Reporting**

\_\_\_\_\_  
**Date**

YOUR RIGHTS IN THE TEXAS WORKERS'  
COMPENSATION SYSTEM

**1. You may have the right to receive benefits**

You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefit if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured by another person for personal reasons, you were injured voluntarily participating in an off-work activity, you were injured by an act of God, or your injury occurred during horseplay.

**2. You have the right to receive the medical care reasonable and necessary to treat your work related injury or illness for the rest of your life.**

**3. You have the right to the initial choice of doctor.**

You may not change doctors except with the approval of the Commission. You do not need to get approval to go to a different doctor for emergency treatment if you or your doctor moves or if your doctor is unable to continue treating you.

**4. You have the right to hire an attorney to help you get benefits or to help you resolve disputes.**

**5. You have the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding, from a Commission ombudsman free of charge. To request assistance, contact the field office handling your claim or call 1-800-252-7031.**

You have the right to receive information and assistance regarding your claim. Commission staff will explain your rights and responsibilities under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Commission ombudsman in informal dispute resolutions and in administrative proceeding if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you.

**6. You have the right to confidentiality.**

Only people who need to know such as your doctor, your employer or your employer's insurance carrier may see information in the commission's files. A prospective employer may get limited information from the commission about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for them to do so.

YOUR RESPONSIBILITIES UNDER THE TEXAS  
WORKERS' COMPENSATION SYSTEM

**1. You have the responsibility to notify your employer about your injury or illness.**

You must notify your employer within 30 days of the date you were injured, or within 30 days of the date you first knew your illness might be work-related. You or someone helping you, may either talk with or write your employer or any supervisor where you work.

If you do not notify your employer within 30 days, you could lose your rights to get benefits.

**2. You have the responsibility to fill out a claim form and send it to the Commission**

You must send a completed claim form, called a TWCC-41 to the Commission within one year of the date you were injured, or within one year of the date you first knew your illness might be at work-related.

Send the completed claim form to the Commission even if you are already getting benefits.

*If you do not send the form within one year, you could lose your right to get benefits.* For a copy of the form call the field office handling your claim, or your income, call 1-800-252-7031.

**3. You have the responsibility to tell the Commission and the insurance carrier any time your income changes.**

If you are NOT getting benefits and you have changed employers since your injury, notify the Commission if it causes you to miss work or lose income, call 1-800-252-7031.

If you ARE getting benefits and you have changed employers since your injury, notify the commission and the insurance carrier paying your benefits if your income changes. Notify the Commission and the insurance carrier regardless of whether your income went up or down.

If you have stopped working since your injury, notify the Commission and the insurance carrier if you start working again or if you have a job offer.

**4. You have the responsibility to notify your doctor you were injured and if you believe it may be work related.**

If possible, tell the doctor before the doctor treats you.

**5. You have the responsibility to notify the Commission and the insurance carrier how to contact you.**

You should contact the Commission and the insurance carrier if your home address, work address, or phone number changes, so the commission and the insurance carrier will be able to contact you when necessary.

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Employee Signature

Date

**EMPLOYEE MEDICAL RELEASE AUTHORIZATION**

I, \_\_\_\_\_ am reporting a work related  
( ) illness ( ) injury that occurred on \_\_\_\_\_.

I have been told by \_\_\_\_\_ that I have the right to visit the doctor of my  
choice regarding this incident; however, at this time I am not in need of medical attention.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Copies: 1- Supervisor  
1- Employee  
1- Payroll Clerk

I WOULD LIKE TO OBTAIN THE FOLLOWING BENEFIT:

(Circle and Initial One)

1. \_\_\_\_\_ WORKERS' COMPENSATION: SECTION 408.103  
States an employee receives 75% of their average weekly if they make less than \$8.50 per hour. If they make \$8.50 or more, they will receive 70% of the average weekly wage. There is a seven day waiting period that the employee will not receive from workers' compensation, unless they are out for four weeks.
  
2. \_\_\_\_\_ ALL OF SICK DAYS  
After all sick leave has been exhausted. Workers' Comp. will start indemnity payments. Payments of sick leave days will be made at 100% salary. After exhausting sick leave days, payment of Workers' Comp. will be made as per 1. above.
  
3. \_\_\_\_\_ PARTIAL SICK DAYS  
This depends on how many days the employee decides to take, leaving some in sick leave file. Thereafter, Workers' Comp. will start compensation, as per 2. above.

IF WE (STUDENT SERVICES DEPT.) DO NOT RECEIVE THIS FORM BACK WITHIN 2 DAYS OF NOTICE WE WILL ASSUME WORKERS' COMPENSATION IS YOUR CHOICE.

If you need further assistance, please call Juanie Garcia at 716-6759 or fax information to 488-6332.

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE

**MEDICAL AUTHORIZATION**

This is to verify the below named person, an employee of Rio Grande City C.I.S.D., has reported a work related injury or illness and is entitled to select the hospital, doctor, and pharmacy of his/her choice for treatment or medication.

**Employee:** \_\_\_\_\_ **Position/Department:** \_\_\_\_\_

**Date of Injury/Illness:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Accident and Injury Description:** \_\_\_\_\_

\_\_\_\_\_

**Authorized Signature:** \_\_\_\_\_ **Title:** Workers' Comp. Secretary

**Date:** \_\_\_\_\_

**FOR PHYSICIANS USE ONLY**

**Treatment Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Diagnosis/Prognosis:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Treatment Administered:** \_\_\_\_\_

\_\_\_\_\_

**Medication Prescribed:** \_\_\_\_\_

**Return to:**     Regular Work     Home     Hospital

**Any Work Restrictions: (If so request job description)** \_\_\_\_\_

\_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

TriSurant  
100 Glenborough Drive, Suite 450  
Houston, TX 77067-3614  
Phone: (281) 873-8682 ext. 213  
Fax: (281) 873-5328

Send Original to:  
Student Services  
Fort Ringgold  
Rio Grande City, TX 78582  
Workers' Comp. Secretary  
Juanita Garcia  
Phone: (956)716-6759  
Fax: (956) 488-6332



Workers' Compensation  
Rio Grande City Consolidated Independent School

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To Whom It May Concern:

\_\_\_\_\_ was injured on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
bills are to be sent directly to the following address.

TriSurant  
100 Glenborough Drive, Suite 450  
Houston, Texas 77067-3614  
Phone: (281) 873-8682  
Fax: (281) 873-5328  
e-mail: [www.TriSurant.com](http://www.TriSurant.com)

For further information on medical or medication is needed call:

Patty Moore  
1-800-749-2714 ext. 213

If we can be of further assistance, please let us know.

Thank you,

San Juanita Garcia  
Workers' Comp. Secretary  
Phone: (956) 716-6759  
Fax: (956) 488-6332