***** NOTICE ******

Is your non-subscribing employer in compliance with Texas Department of Insurance, Division of Workers' Compensation requirements?

Please review the attached information with your client as the fine has increased to a possible, maximum fine of $25,000 PER DAY if the Employer is not in compliance.

Confirmation that the client has been notified:

______________________________________ **Agent Signature**

______________________________________ **Date**

Updated Texas Nonsubscriber Forms and Notices Required by the Division of Workers' Compensation

Forms and notices used by Texas nonsubscribers were updated recently to reflect the new administration by the Texas Department of Insurance (TDI), Division of Workers' Compensation (DWC) – formerly administered by the Texas Workers' Compensation Commission. The mandatory date to begin using the revised DWC forms is May 1, 2006, although nonsubscribers may begin using the new forms immediately. The new forms and their uses are listed below:

New Name	Previously	Use
DWC Form-5	TWCC 5	**Notice to State of Texas:** Notifies the DWC if a business chooses to become a nonsubscriber. This form must be filed initially within 10 days after notifying the insurance carrier of cancellation and annually on the anniversary date of the original filing.
DWC Form-205	TWCC 205	Lists additional business locations of a nonsubscriber. Used in conjunction with DWC Form-5 above.
DWC Notice 5 DWC Notice 5s	TWCC Notice 5 TWCC Notice 5s	**Notice to Employees and Workplace Posters:** Notifies employees of employers nonsubscriber status. This notice must be posted in the workplace in English, Spanish and other language common to the workplace within 15 days of the employer dropping or canceling insurance coverage. Written notice must also be distributed to all Texas employees using this same language.
DWC Form-7 DWC Form-7s	TWCC 7 TWCC 7 Supp.	**Lost Time/OD/Death Claim Notice:** Reports all fatalities, occupational diseases and on-the-job injuries resulting in more than one days absence from work for the injured employee. Must be filed no later than the 7th day of the month following the reported incident.

These forms and notices can be found on the TDI website at http://www.tdi.state.tx.us/wc/forms/index.html

The new Texas workers' comp laws now make failure to comply with the above requirements an administrative violation carrying a penalty up to $25,000 per day per occurrence, with each day of noncompliance constituting a separate violation.

HOW TEXAS EMPLOYERS CAN BECOME NON-SUBSCRIBERS

I. Review Directions and Complete the attached DWCC 5 form

WHEN: 1. This action should be taken at least **30 days** before the date on which the Employer wants to commence Non-Subscriber status or
2. No later than 10 days after the Employer notifies their Workers Compensation carrier to terminate coverage.

HOW: Send DWCC form 5 by **Certified Mail/Return Receipt** to:

Texas Department of Insurance
Division of Workers Compensation
7551 Metro Center Drive
Suite 100
Austin, Texas 78744

NOTE: **Until** the Employer completes the DWCC 5 notice requirement, injured employees will remain eligible for Workers Compensation benefits. Eligibility is **not** dependent upon employer having purchased Workers Compensation coverage or not.

II. Notify the Insurance Carrier that you are canceling or not renewing your policy.

WHEN: Not later than the renewal date of the policy or the date on which you wish to officially become a Non-Subscriber

HOW: With a written request.

III. Notify all current employees that you are no longer a subscriber to Workers Comp and OBTAIN a signed "ACKNOWLEDGMENT DOCUMENT".

WHEN: No later than the 15th day following the EFFECTIVE DATE on which coverage will be CANCELED (or NON-RENEWED)

HOW: Post (in two visible locations (ie HR office & by time clocks) the following official notice:

NOTICE OF NO WORKERS' COMP which includes: NOTICE OF TOLL FREE NUMBER FOR REPORTING WORKPLACE VIOLATIONS.
Must be posted in English and Spanish

HOW: Use a special ACKNOWLEDGMENT DOCUMENT (ED1) confirming the employees' awareness of NO WORKERS' COMP INSURANCE and having seen the posted notices.

Send DWC FORM-5 by certified mail or personal delivery to:
TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

EMPLOYER NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE

INSTRUCTIONS

WHO MUST FILE: All employers (including former sole proprietors who have formed corporations which have only one employee) must file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation **unless** the employer:

a. has workers' compensation insurance;
b. is a certified self-insurer;
c. is a self-insured political subdivision; or
d. only employs employees who are exempt from coverage under the Texas Workers' Compensation Act.

WHEN TO FILE: See reverse side of form.

NO COVERAGE OR TERMINATION OF COVERAGE

1. Check one of the following:

☐ The below named employer **ELECTS NOT** to obtain workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.004.

☐ The below named employer has **TERMINATED** workers' compensation insurance coverage, effective date ______________ of Policy Number ______________ and has notified the ______________ Insurance Company on (date) ______________, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007. Notice has been (will be) provided to employees on the following date: ______________.

EMPLOYER INFORMATION (PLEASE TYPE OR PRINT:)

2. Employer Business Name	3. Federal Tax ID Number
4. Employer Business Mailing Address	
5. Description of Business Operations. Identify type and nature of business.	

6. Name, Federal Tax ID Number and Address of <u>each</u> Business Location covered by this report, if different from the above. To identify additional locations, submit a DWC FORM 205.

Name ______________
Address ______________
City ______________ State _____ Zip _______ Federal Tax ID Number ______________

Name ______________
Address ______________
City ______________ State _____ Zip _______ Federal Tax ID Number ______________

PERSON PROVIDING THIS INFORMATION	
7. Name	
8. Title	
9. Signature	10. Date

DIVISION DATE STAMP HERE:

DIVISION OF WORKERS' COMPENSATION

INSTRUCTIONS FOR
EMPLOYER NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE

The following employers are required to file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation:

1. Employers who elect not to be covered by workers' compensation insurance must file a DWC FORM-5 by the **earlier** of:
   a. 30 days after hiring an employee who is subject to coverage under the Texas Workers' Compensation Act; or
   b. 30 days after receipt of a Division request for filing of a DWC FORM-5;

2. Employers principally located outside Texas must file a DWC FORM-5 within 10 days after receipt of a Division

   request for information regarding coverage status; or

3. Employers who cancel their workers' compensation insurance must file a DWC FORM-5 within 10 days after notifying their insurance carrier of cancellation **unless** the employer:
   a. purchases a new policy; or
   b. becomes a certified self-insurer.

If an employer chooses to cancel their insurance, coverage must be extended until the "effective date" of withdrawal (i.e., the **later** of 30 days after filing the DWC FORM-5 with the Division OR the policy cancellation date), during which time the employer is obligated to pay accrued premiums. The employer is not required to extend coverage beyond the end of the policy period.

ANNUAL FILING: Employers must file a new DWC FORM-5 **annually** on the anniversary date of the original filing.

APPLICATIONS/EXEMPTIONS: An employer who is: (1) covered by workers' compensation insurance; (2) a certified self-insurer; (3) a self-insured political subdivision; or (4) whose only employees are exempt from coverage under the Texas Workers' Compensation Act (e.g. domestic workers, certain farm and ranch workers) is not required to file a DWC FORM-5.

POSTING AND NOTICE REQUIREMENTS

An employer must **post** the following notice in the workplace in English, Spanish and other language common to the workplace in the print type specified by Workers' Compensation Rules whenever the employer: (1) elects not to be covered by workers' compensation insurance; (2) cancels or terminates workers' compensation insurance; (3) withdraws from self-insurance; or (4) whose workers' compensation coverage is cancelled by the insurance company. This notice must **also be provided** to each mployee:

a. at the time of hiring;
b. when an employer elects not to be covered by workers' compensation insurance;
c. within 15 days of when an employer notifies the insurance carrier that the employer is dropping coverage without maintaining continuous coverage under a new policy; or
d. within 15 days of when an employer's workers' compensation policy is canceled by the insurance company.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (______________________________) has elected not to obtain workers' compensation insurance coverage.
Name of Employer

As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Workers' Health & Safety at 1-800-452-9595.

Failure to file a DWC FORM-5 or to post or provide the required notices may subject the employer to administrative penalties.

Primary Employer's Business Name/Insured	Federal Tax ID No.	Current Policy No.	DWC Use Only (Microfilm)

LOCATIONS OF EMPLOYERS' BUSINESS(ES)

Please Type ☐ DWC FORM-5 ☐ DWC FORM-20

Please list additional locations, subsidiaries, and/or separate entities of the primary employer for attachment to forms DWC FORM-5, DWC FORM-20 and DWC FORM-20A. If filing this form with a DWC FORM-20A, indicate if the listed location is an addition or deletion to the existing policy.

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

Name ______________________ Check One: ☐ ADD ☐ DELETE
Address ______________________ Effective Date ______________________
City __________ State ______ Zip ______ Federal Tax ID Number ______________________

NON-COVERED EMPLOYER:

Texas Workers' Compensation Rule 110.101(e)(3) requires employers who elect not to be covered by workers' compensation, or who cancel or terminate coverage to advise their employees that they have elected not to be covered.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

(1) Prominently displayed in the employer's personnel office, if any;

(2) Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;

(3) Printed with a title in at least 30 point bold type, subject in at least 20 point bold type, and text in at least 19 point normal type; and

(4) Contain the exact words as prescribed in Rule 110.101(e)(3).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

DO NOT POST THIS SIDE

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (__________________________________) has elected not to
Name of Employer

obtain workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Workers' Health & Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [______________________________] ha elegido no
Nombre del Empleador

obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común" de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque él o ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.

INSTRUCTIONS FOR COMPLETING THE NON-COVERED REPORT OF OCCUPATIONAL INJURY OR ILLNESS (DWC FORM-7)

All on-the-job injuries resulting in more than one day lost time, all occupational diseases of which the employer has knowledge (regardless of lost time), and all fatalities occurring during the calendar month must be reported. If no such injuries, diseases or fatalities have occurred during the calendar month, no report is required. Lost time begins the day after the day of the injury. For example, an employee injured on 1-1-92 who returns to work on 1-4-92 would have a lost time of 2 days since the day of the injury does not count, nor does the day the employee returned.

Use as many supplemental sheets as needed (form can be reproduced). The first sheet must have all Employer as well as Injury Data completed. Subsequent sheets must have the Employer's Business Name, Federal Employer Identification Number, and Injury Data completed.

The completed form must be personally delivered or mailed **not later than the seventh day** of the following month to the:

Texas Department of Insurance
Division Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

Month - Enter the calendar month. Year - Enter the calendar year.

Employer Data

ITEM: INSTRUCTIONS:

1. **Employer's Business Name** - Use employer DBA (Doing Business As). If employer does not have a DBA, use other business name.
2. **Federal Employer ID No.** - (FEIN) Obtain this number from financial or tax account records. If the employer has more than one FEIN, use a separate DWC FORM-7 for each separate FEIN.
3. **Telephone Number** - Business telephone number of the individual completing the report.
4. **Employer's Business Mailing Address** - Give the street address and post office box number (if applicable).
5. **City, County, State, Zip** - Name of County must be included.
6. **Employer's Representative** - Print or type name and title of individual completing the report.
7. **Employer's Representative's Signature** - Signature of Employer's Representative certifying the information provided on the form is correct.
8. **Employer's Six-Digit NAICS Codes With Employment - List all 6-digit NAICS Codes which the employer uses with the FEIN specified in block 1 only.** If unknown, consult Texas Workforce Commission Form C-3, Employer's Quarterly Report, block 5, for this information. Give the highest employment figure for each NAICS Code for the month of the report. Employment means all employees on your payroll whether full-time, part-time, temporary, or permanent. Use a separate sheet for information that does not fit in the block.**

Injury Data

9. **Employee's Name** - List the full name of the individual who suffered an injury, occupational disease, or fatality.
10. **Date of Injury/Illness** - Enter the date the injury occurred or the date the employer first had knowledge of the occupational disease.
11. **Employee 6-Digit NAICS** - List the 6-digit NAICS Code of the activity that the employee was engaged in at the time of the injury/illness. The code listed must be one of the 6-digit NAICS Code numbers reported by the employer in block 8. If NAICS Codes are unknown, consult Texas Workforce Commission (TWC) Form C-3, Employer's Quarterly Report, block 5, for this information.**
12. **Equipment** - List equipment (if any) involved in the injury.
13. **Nature of INJ/Ill** - Enter the type of injury/illness. For example: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. Use most serious condition if multiple injuries.
14. **Body Part(s) Affected** - List the most seriously injured part(s). for example: head, hand, torso, leg, back, ankle, wrist, lungs, skin, eyes.
15. **Social Security Number** - Enter the Employee's Social Security Number.
16. **Sex** - Check appropriate block. Information as to the sex of the employee will be maintained for non-discriminatory statistical use.
17. **DOB** - DATE OF BIRTH - Enter month, day and year.
18. **Race/Ethnic Identification** - Check appropriate block. Information as to the race/ethnicity of the Employee will be maintained for non-discriminatory statistical use.
    NOTE: "HISPANIC", while not a race identification, is included as a separate race/ethnic category. Do not include Hispanic under "white" or "black."
19. **Cause of Injury** - Give the most probable cause of injury/illness. Example: Overexertion due to lifting or pushing; caught between; slip; trip; fall.
20. **Location of Injury** - Check block A if injury occurred at primary business location. Check block B if injury occurred at on-site job location. Check block C if injury occurred while traveling between work locations.
21. **Occupation** - List the type of work the injured individual was engaged in at the time of the injury/illness. For example: carpenter, pipe fitter.
22. **Description of Incident** - Give a short narrative of how the incident occurred. For example, "While painting house, fell off ladder and fractured arm.
23. **Lost Time** - If the employee lost more than one day after the date of the injury but less than 8 days, check > 1 Day - 7 Days. If the employee lost 8 or more days check the 8 Days or More block.
24. **Occupational Disease** - If employee suffered an Occupational Disease, check "YES", if not, check "NO."
25. **Fatality** - Did the injury/illness result in the death of the employee? If yes, check "YES" and list date of death. If no, check "NO."
26. **DO NOT WRITE IN THIS BLOCK. IT IS RESERVED FOR TWCC USE ONLY.**

** For companies that do not report to TWC, NAICS code can be found in the North American Industry Classification System published by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161, e-mail: info@ntis.fedworld.gov.

DWC FORM - 7
(Non-covered Employer's Report of Occupational Injury or Illness)

Certain non-covered employers, described below, are required to file reports with DWC using DWC FORM-7, Non-covered Employer's Report of Occupational Injury or Illness. Employers must list on the DWC FORM-7 all fatalities, all occupational diseases of which the employer had knowledge (even if there is no lost time) and all on-the-job injuries resulting in more than one day's absence from work for the injured employee. The completed DWC FORM-7 reporting all such injuries that have occurred during a calendar month must be filed no later than the 7th day of the following month.

Non-covered employers are required to file this form if they have more than 4 employees*

* All employees are counted for these requirements unless they are domestic workers, or casual workers engaged in employment incidental to a personal residence, or are certain farm and ranch workers, or are workers covered by a method of compensation established under federal law.

The DWC FORM -7 is considered filed when personally delivered or postmarked. Send the DWC FORM-7 and the DWC FORM-7 Supplemental to the Texas Department of Insurance, Division of Workers' Compensation, Customer Services, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

(Rule 160.2 Non-Subscribing Employer's Report of Injury)

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
Customer Services
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

NON-COVERED EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

REPORT FOR MONTH OF: __________ YEAR: ________

EMPLOYER DATA

1. Employer's Business Name	2. Federal Employer ID No.	3. Telephone No.
4. Employer's Business Mailing Address (Street or P.O. Box)		
5. City / County / State / Zip		
6. Employer's Representative (Print/Type Name and Title of Person Completing Form)	7. Employer's Representative's Signature	
Last / First / MI	I certify the information provided is correct	Date (m-d-y)

8 NAICS CODES /Employment	
NAICS Codes	NAICS Employment

INJURY DATA

1 Employee's Name: Last / First / MI

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

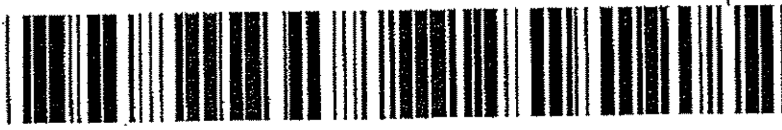
- 15. Social Security Number
- 16. Sex ☐ M ☐ F
- 17. DOB (m-d-y)
- 18. Race/Ethnic Identification: ☐ White (not of Hispanic origin) ☐ Black (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
- 19. Cause of Injury
- 20. Location of Injury (see Instructions) ☐ A ☐ B ☐ C
- 21. Employee's Occupation
- 21a. Hourly Wage
- 22. Description of Incident
- 23. Lost Time ☐ > 1 Day - 7 Days ☐ 8 Days or More
- 24. Occupational Disease ☐ YES ☐ NO
- 25. Fatality ☐ YES ☐ NO Date (m-d-y)
- 26. DWC USE ONLY: OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS ____

2 Employee's Name: Last / First / MI

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

- 15. Social Security Number
- 16. Sex ☐ M ☐ F
- 17. DOB (m-d-y)
- 18. Race/Ethnic Identification: ☐ White (not of Hispanic origin) ☐ Black (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
- 19. Cause of Injury
- 20. Location of Injury (see Instructions) ☐ A ☐ B ☐ C
- 21. Employee's Occupation
- 21a. Hourly Wage
- 22. Description of Incident
- 23. Lost Time ☐ > 1 Day – 7 days ☐ 8 Days or More
- 24. Occupational Disease ☐ YES ☐ NO
- 25. Fatality ☐ YES ☐ NO Date (m-d-y)
- 26. DWC USE ONLY: OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS ____

Commission date stamp



EMPLOYER DATA

1. Employer's Business Name	2. Federal Employer ID No.

REPORT FOR MONTH OF: ________ YEAR: ________

INJURY DATA

3 Employee's Name
Last ____ First ____ MI ____

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number | 16. Sex ☐ M ☐ F | 17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time
☐ >1 Day - 7 Days
☐ 8 Days or More

24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation | 21a. Hourly Wage

26. DWC USE ONLY
OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS ____

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

4 Employee's Name
Last ____ First ____ MI ____

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number | 16. Sex ☐ M ☐ F | 17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time
☐ >1 Day - 7 Days
☐ 8 Days or More

24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation | 21a. Hourly Wage

26. DWC USE ONLY
OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS ____

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

5 Employee's Name
Last ____ First ____ MI ____

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number | 16. Sex ☐ M ☐ F | 17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time
☐ >1 Day - 7 Days
☐ 8 Days or More

24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation | 21a. Hourly Wage

26. DWC USE ONLY
OCC ____ NAT ____ BOD ____ SRCE ____ ACCDT ____ AOS ____

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

data stamp