Workers Compensation Non-Subscriber Form

Texas is unique in one very important respect: It's the only state in which employers have the choice to carry workers' compensation insurance or not. There are two ways an employer chooses not to purchase workers' comp or "opt out" of the worker's compensation system.

By "choice" – chooses to carry alternative coverage

By "default" – does not carry any coverage

If an employer does not purchase workers' comp either by choice or default, they must file state mandated forms and post required notices to avoid fines and penalties. Below is a list of required forms/postings. For your convenience, these forms are available on the GHRA Website under Members in **members' resources** section http://www.ghraonline.com/Members.php.

DWC Form-5: must file annually. This form tells the state that the employer is not carrying workers' compensation insurance.

DWC Form-7: must file for every fatality or occupational disease, and every work-related injury that results in more than one day of lost time. Applies to employers with at least 5 employees

Post the required notices: notify employees of the decision to "opt out" with the TDI's prescribed posters, which should be placed in at least one prominent area such as a break-room wall or bulletin board.

Administrative penalties assessed by the Texas Department of Insurance for not filing the required forms can be as much as $25,000 per day.

DWC Form-5

The Division of Workers' Compensation at the Texas Department of Insurance (TDI-DWC) has revised the DWC Form-5 and the DWC Form-205, the nonsubscriber filing forms associated with notifying the state of the employers' status as a Texas nonsubscriber. Nonsubscribers are required to begin utilizing the new forms on February 1, 2011.

This form can be filled out Online instead of mailing in the attached form. Please go to:

https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp

Choose "Employer Online Filings".

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

Employer Notice of No Coverage or Termination of Coverage

Type or print each item on this form in black ink
-OR-
Submit through Employer Online Filings at:
https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp

I. REQUIRED STATEMENTS

1. Statement of No Coverage

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

☐ The employer named below **HAS TERMINATED** workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007.
Policy terminated effective (mm/dd/yyyy):
Policy number:
Insurance company:
Insurer informed of termination on (mm/dd/yyyy):
Employees were (will be) notified on (mm/dd/yyyy):

The election selected above is effective from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy). The effective dates cannot exceed a one-year period.

2. Statement of Reportable Injuries or Illnesses
Did you have any reportable employee injuries or illnesses since your last *Employer Notice of No Coverage or Termination of Coverage*? ☐ Yes ☐ No
If your response is "Yes", you may be required to file a DWC Form-007, *Non-covered Employer's Report of Occupational Injury or Illness.*
(See the Frequently Asked Questions section of this form.)

II. PRIMARY EMPLOYER INFORMATION

3. Employer Business Name	**4. Federal Employer ID Number**
5. Employer Business Mailing Address (Street or PO Box, City State Zip)	
6. Employer Business Type	**7. Six-Digit NAICS Code**

III. ADDITIONAL BUSINESS LOCATIONS

Provide name, Federal Employer ID number and address of <u>each</u> Texas business location, subsidiary, or separate entity of the primary employer covered by this report. If more space is needed to identify additional locations, submit a DWC Form-205, *Locations of Employer's Business(es).*

8. Name	**9. Federal Employer ID Number**
10. Address (Street or PO Box, City State Zip)	
11. Name	**12. Federal Employer ID Number**
13. Address (Street or PO Box, City State Zip)	
14. Name	**15. Federal Employer ID Number**
16. Address (Street or PO Box, City State Zip)	
17. Name	**18. Federal Employer ID Number**
19. Address (Street or PO Box, City State Zip)	

IV. PERSON PROVIDING INFORMATION

20. Name	**21. Telephone Number**	For TDI-DWC Use Only
22. Title	**23. E-mail Address**	
24. Signature	**25. Date**	

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Frequently Asked Questions
Employer Notice of No Coverage or Termination of Coverage

Who must file the DWCForm-005?
All employers (including former sole proprietors who have formed corporations which have only one employee) must file a DWC Form-005 with the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) **except** an employer who:

- has workers' compensation insurance;
- is a certified self-insurer;
- is a self-insured political subdivision; or
- employs only employees who are exempt from coverage under the Texas Workers' Compensation Act (for example, domestic workers, certain farm and ranch workers).

Where/when do I file the form?
Fax the form to TDI-DWC at (512) 804-4146 or mail it to the address at the top of the form. The following deadlines apply to the filing of the DWC Form-005.

- An employer **who elects not to be covered** by workers' compensation insurance must file the DWC Form-005:
  - within 30 days of hiring an employee who is subject to coverage under the Texas Workers' Compensation Act; or
  - within 30 days (10 days if the employer is **principally located outside Texas)** of receipt of a TDI-DWC request for coverage status, whichever comes first.

- An employer **who cancels workers' compensation insurance** must file within 10 days after notifying the insurance carrier of cancellation unless the employer purchases a new policy or becomes a certified self-insurer.

NOTE: Employers must file the DWC Form-005 **annually on the anniversary date of the original filing** as long as they remain in operation and do not carry workers' compensation insurance.

How/when must a non-covered employer notify employees that workers' compensation coverage is not provided?
An employer **must post** the *Notice to Employees Concerning Workers' Compensation in Texas* in the workplace in English, Spanish and any other language common to the employer's employee population in the print type specified by TDI-DWC rules whenever the employer:

- elects not to be covered by workers' compensation insurance;
- cancels or terminates workers' compensation insurance;
- withdraws from certified self-insurance; or
- has its workers' compensation coverage cancelled by the insurance company.

The employer **must also provide** this notice to each employee:

- at the time of hiring;
- when the employer elects not to be covered by workers' compensation insurance;
- within 15 days of notification to the insurance carrier that the employer is dropping coverage unless the employer maintains continuous coverage under a new policy or becomes a certified self-insurer; or
- within 15 days of cancellation by the insurance company.

The required notice is attached and may also be found at:
http://www.tdi.state.tx.us/forms/dwc/notice5.pdf (English) and http://www.tdi.state.tx.us/forms/dwc/notice5s.pdf (Spanish).

If an employer chooses to cancel workers' compensation insurance, when does coverage end?
The insurance carrier must extend coverage for 30 days after the employer files notice with TDI-DWC or until the date of cancellation, whichever is later. Premiums are due until such date.

Are non-covered employers required to file other forms with TDI-DWC?
Employers with 5 or more employees are required to report work-related injuries and illnesses to TDI-DWC. Employers must report each work-related injury or illness by the seventh day of the following month. Non-covered employers should report these injuries and illnesses using the DWC Form-007, *Non-covered Employer's Report of Occupational Injury or Illness*, for each:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

The DWC Form-007 can be obtained at http://www.tdi.state.tx.us/forms/dwc/dwc7.pdf.

WARNING: The following may subject a non-covered employer to administrative penalties:

- failure to file a DWC Form-005
- failure to post or provide required notices and/or
- withholding information or providing fraudulent or inaccurate information

Additional information can be found at http://www.tdi.state.tx.us/wc/employer/filings.html#faq or by calling 1-800-372-7713.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [_____Employer Name_____] has elected not to 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 and Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [_____Nombre del Empleador_____] ha elegido no obtener cobertura de seguro de compensación para trabajadores. Como empleado de un empleador que ha elegido no tener seguro de compensación; usted no puede recibir beneficios de compensación dentro de la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información sobre 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", en caso de que usted sufriese una lesión o enfermedad relacionada con su trabajo. Su empleador debe proporcionarle información sobre la cobertura, por escrito, cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

LÍNEA TELEFÓNICA PARA REPORTAR CONDICIONES INSEGURAS: La División ha establecido una línea gratuita telefónica que está en servicio las 24 horas del día, 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 a cualquier empleado porque el o ella, de buena fe, reporta una supuesta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al número 1-800-452-9595.

DWC205

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

For TDI-DWC Use Only

Locations of Employer's Business(es)

Addendum to DWC Form-005 or DWC Form-020

Type or print each item on this form in black ink

Check the appropriate box:

☐ **Addendum to DWC Form-005** ***Employer Notice of No Coverage or Termination of Coverage***

☐ **Addendum to DWC Form-020** ***Insurance Carrier Notice of Coverage or Cancellation/Non-renewal of Coverage***

I. PRIMARY EMPLOYER INFORMATION

Primary Employer's Business Name	Federal Employer ID Number

II. ADDITIONAL BUSINESS LOCATIONS

Use this section to add or delete coverage for locations, subsidiaries, and/or separate entities of the primary employer.

Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ **ADD** ☐ **DELETE**	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

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.

EMPLEADORES SIN COBERTURA:

El Reglamento 110.101 (e)(3) del Departamento de Seguros de Texas, División de Compensación para Trabajadores requiere que el empleador que haya elegido no tener cobertura de seguros de compensación para trabajadores, o quien ha cancelado o anulado su cobertura notifique a sus empleados que ellos han elegido no tener cobertura.

Avisos en Inglés, Español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista del público y:

(1) Mostrar muy a la vista en un lugar de la oficina de personal del empleador, si es que la hay;

(2) Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;

(3) El título debe ser impreso en tamaño 30, letra negrita de punto, el tema debe ser impreso en tamaño 20, con letra negrita de punto, y el texto, por lo menos en tamaño 19 punto tipo normal.

(4) Debe contener las palabras exactas como se ha señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra en el reverso de esta página cumple con los requerimientos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la ley y reglamentos de la División.

NO MOSTRAR ESTE LADO

DWC Form-7

This form needs to be filed for 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 fatalites occurring during the calendar month must be reported. This form must be delivered or mailed no later than the 7th day of the following month.

For more information regarding these forms please go to the Texas Department of Insurance website http://www.tdi.state.tx.us/forms/form20employer.html

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 DWC 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
Records Processing MS-94
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) ☐ 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)

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) ☐ 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)

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)

date stamp