

Fax completed form to Human Resources, CPC: 972-548-6716

Human Resources will send this form to the Workers' Compensation Insurance Carrier if a doctor is seen or time is lost. If not, this form is used as an Incident Report only.
Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM # To be assigned later _____

CARRIER'S CLAIM # To be assigned by Workers' Comp. Carrier _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
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 White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity 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 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 (IF THIS DOCTOR WAS OR WILL BE SEEN DUE TO THE INJURY)			
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 _____
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 (Injured Employee, Employee's Supervisor or Admin. Asst.)		41. Name of Business HR Contact Person: Melanie M. Tracht, Central Park Campus Collin County Community College District	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Phone: 972/548-6664 Number and Street Central Park Campus, HR Dept., Melanie M. Tracht, 2200 W. University Dr.	
City State Zip Code		City State Zip Code McKinney TX 75070	
44. Federal Tax Identification Number 75-2037156	45. Primary Standard Industrial Classification (SIC) Code* 61121	46. Specific SIC Code* 8222	47. Texas Comptroller Taxpayer No. 999929184
48. Workers' Compensation Insurance Company Deep East Texas Self-Insurance Fund		49. Policy Number 0225	
50. Did the injured employee 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"/>			
51. Signature and Title X _____ Date _____			

HR WC Coordinator Signature: _____ Melanie M. Tracht, CCCCD Manager of Benefits Date: _____