Send the specified copies to your
Worker's 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 - -	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? If No, Specify Language YES ☐ NO ☐			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	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City	State	Zip Code
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	
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 (6 digit) Code:	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 ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

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

X_____ Date_____

DIVISION OF WORKERS' COMPENSATION

EMPLOYEE REPORT OF ACCIDENT/INCIDENT

Calhoun County Independent School District

Name of Injured Employee: _____

Date of accident: _____ Time: _____ a.m. /p.m. Date of birth: _____

SS# _____ Job Title: _____ Your Hired Date: _____

Mailing address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Marital Status: _____ Spouse's Name: _____

Number of Dependents: _____ Race: _____ Do you speak English? _____

Campus or location of accident: _____ Place where accident occurred: _____

List witnesses: _____

List detailed description of accident:

_____

_____

_____

_____

_____

Describe injury (part of body affected): _____

_____

Did you seek medical attention: ☐ Yes ☐ No If so, doctor or ER? _____

How could this accident have been prevented? _____

_____

Supervisor's Name: _____ Phone: _____

_____ _____

Signature of Injured Employee **Date**

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Calhoun County Independent School District

SUPERVISOR'S REPORT OF ACCIDENT/INCIDENT

Name of Supervisor: _____ Title: _____

Campus/Department: _____ Address: _____

City: _____ Zip: _____ Phone: _____

Name of Injured Employee: _____

Date of accident: _____ Time: _____ a.m. or p.m.

Campus or location of accident: _____

Witness: _____ Place where accident occurred: _____

Detailed description of accident: _____

_____

_____

_____

_____

_____

Did employee seek medical attention? ☐ Yes ☐ No If yes, doctor or ER? _____

How could accident have been prevented? _____

_____

_____ _____

Supervisor's Signature **Date**

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Calhoun County Independent School District

WITNESS REPORT OF ACCIDENT

Name of Witness: _____ Position: _____

Department or Campus: _____ Address: _____

City: _____ Zip: _____ Phone: _____

Name of Injured Employee: _____

Campus or Location of accident: _____

Date of accident: _____ Time: _____ a.m. or p.m.

Complete detailed description of accident: _____

_____

_____

_____

_____

_____

Describe injury: (part of body affected): _____

_____

_____

_____ _____

Signature of Witness **Date**

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Calhoun County Independent School District

NURSE'S REPORT OF ACCIDENT

Name of Employee: _____ Position: _____

Department or Campus: _____ Place where accident occurred: _____

{Vital Signs} B/P:_____ Temperature: _____ Pulse: _____

Date of accident: _____ Time: _____ a.m. or p.m.

Detailed description of accident: _____

_____

_____

_____

_____

Describe First Aid administered: _____

_____

_____

Did employee require further medical attention? ☐ Yes ☐ No

Comments: _____

_____

_____

_____

_____ _____

Nurse's Signature **Date**

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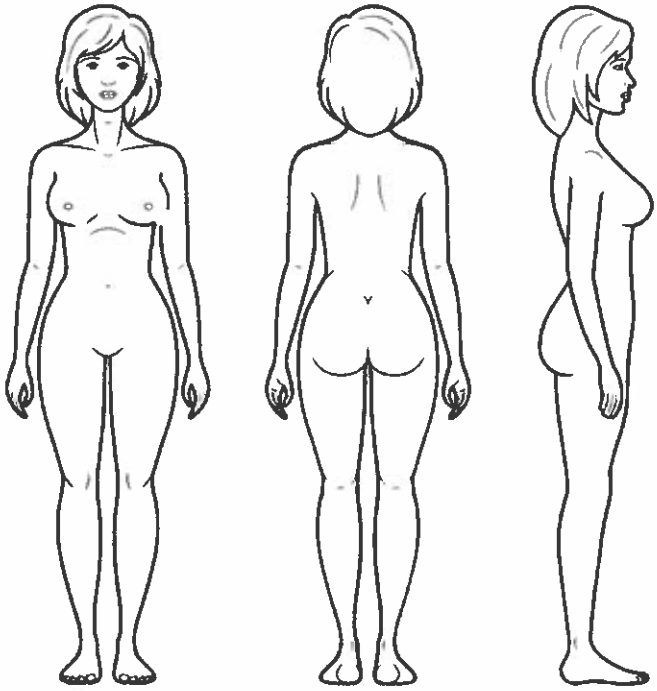
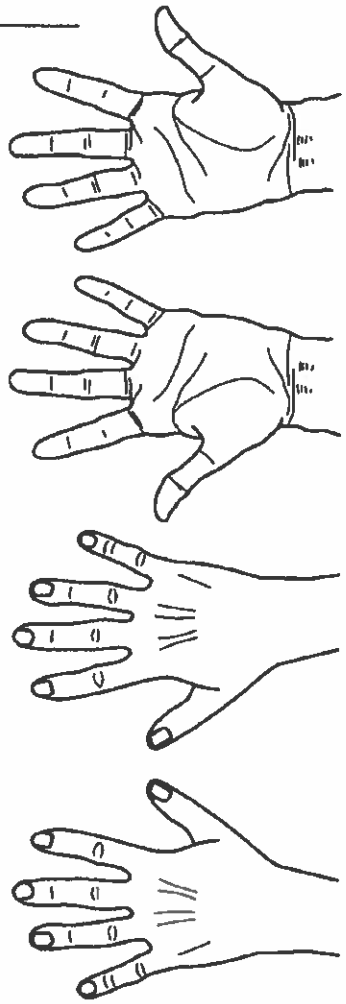
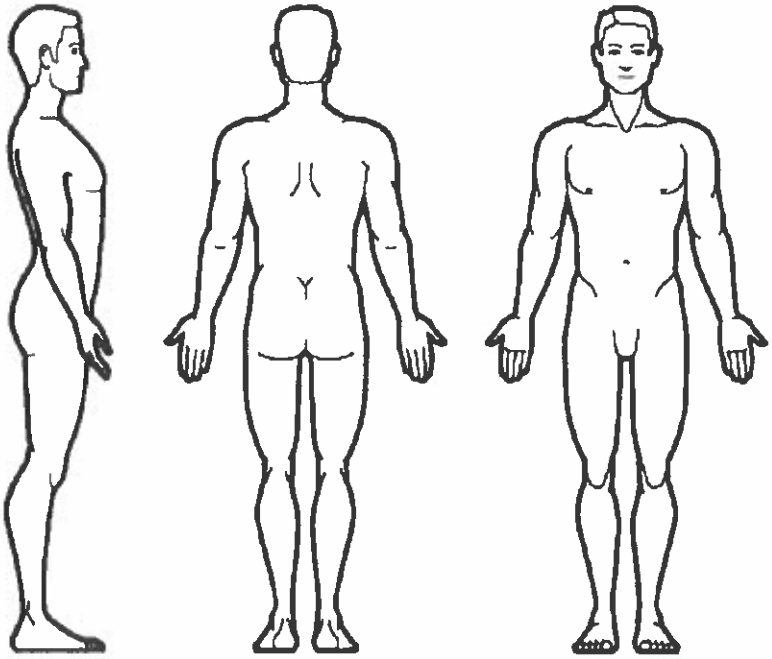
Calhoun County Independent School District

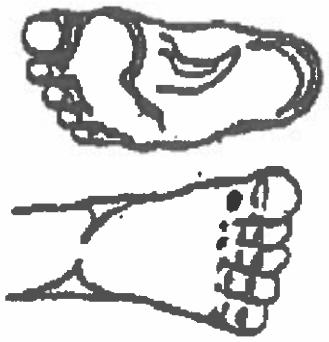
Date of Injury: _____

Injured Employee Name: _____









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HIPAA Authorization for Disclosure of Protected Health Information

I, _____, date of birth _____, Social Security No. _____, authorize the disclosure of my protected health information[1] as described herein. I understand that this authorization is voluntary and made to confirm my direction. I understand that if the person(s) or organizations(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws[2], subsequent disclosure by such person(s) or organizations(s) may not be protected by those laws.

1. I authorize the following person(s) and/or organizations(s) to disclose my protected health Information (as specified below):

   All healthcare providers who have provided healthcare to me.

2. I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organizations(s) below.

   Name: *Claims Administrative Services, Inc.*
   P.O. Box 7500
   Tyler, Texas 75711

   Texas Dept. of Insurance – Division of Workers' Compensation
   7551 Metro Center Drive, Suite 100
   Austin, Texas 78744-1609

   Others: _____

3. Specific description of the protected health information that I authorize for disclosure (authorization to disclose psychotherapy notes must be separate):

   Any and all records regarding my health, including medical histories, consultations, examinations, prescriptions, diagnosis, tests, reports or treatments.

   I further specifically authorize the disclosure of psychotherapy notes, if any.

---

1 Protected health information ("PHI") is health information that is created or received by a health care provider, health plan or health care clearinghouse which relates to 1) the past, present or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be such that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

2 These laws apply to heal plans, health care providers, and health care clearinghouse.

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4. The purpose for requesting this information is for use by the carrier to evaluate, adjust, describe, or report matters about my health to persons entitled to receive this information.

5. I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization.

6. I understand that treatment and payment for my treatment are not conditional on my agreement to this authorization.

7. I understand that the release of protected health information to a non-covered entity may invalidate its protection.

8. I understand that my express consent is required to release any healthcare information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDES virus), sexually transmitted diseases, psychiatric disorder/mental health or drug and/or alcohol use, you are specifically authorized to release all healthcare information related to such diagnosis testing or treatment.

9. This authorization expires on one year from the date of authorization, or the date that my workers' compensation claim is finally closed, whichever occurs first.

I have had the opportunity to read and consider the contents of this authorization. I confirm that this authorization is a true and correct statement of my intention to permit the disclosure of my PHI as described in this authorization.

_____ _____

Signed Date

Name: _____

Address: _____

Telephone: _____ SSN: _____

D.O.B. _____

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