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's Report of Non-covered Employee's Occupational Injury or Disease

Type or print in black ink

☐ **Non-subscribing Employer**
☐ **Subscribing Employer - Employee Waived Workers' Compensation Insurance Coverage**

I. EMPLOYER INFORMATION

1. Employer Business Name		
2. Reporting Period (mm/yyyy)	**3. Number of Injured Employees Included on This Report**	
4. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)	**5. Provide the following:**	
	NAICS Codes	**NAICS Employment**
6. Employer Physical Address (Street, City, State, Zip Code)		
7. Employer Phone Number		
8. Federal Employer ID Number		
9. Name of Person Completing Form		
10. Phone Number of Person Completing Form		
11. Title of Person Completing Form		
12. Signature of Person Completing Form	**13. Date of Signature** (mm/dd/yyyy)	

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**
22. Race/Ethnic Identification ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (specify)		

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23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)	
24. Type of Location Where Injury/Occupational Disease Occurred ☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations	
25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)
27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)	
28. Reported Cause of Injury	
29. Nature of Injury/Occupational Disease	
30. Equipment Involved in the Injury (if any)	
31. Body Part(s) Affected	
32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)
36. Description of Incident	

NOTE[1]: Title 28 Texas Administrative Code, Chapter 160 requires employers to report work-related deaths, on-the-job injuries and occupational diseases in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: 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)

Employer's Name: Employer's FEIN:	For TDI-DWC Use Only

Injury Data for Additional Injured Employee(s)
(reproduce this page, if necessary)

Employer Business Name	
Employer FEIN	**Reporting Period** (mm/yyyy)

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**

22. Race/Ethnic Identification
☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Other (specify)

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)

24. Type of Location Where Injury/Occupational Disease Occurred
☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations

25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)

27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)

28. Reported Cause of Injury

29. Nature of Injury/Occupational Disease

30. Equipment Involved in the Injury (if any)

31. Body Part(s) Affected

32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)

36. Description of Incident

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