Send all specified copies to:

6754 Willowbrook Park Drive, Ste. 200
Houston, TX 77066
Fax (281) 398-1960 or (281) 647-0035

TWCC Claim #	
Carrier's claim #	

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, MI)
2. Sex
3. Social Security Number
4. Home Phone
5. Date of Birth
6. Does the Employee Speak English? If No, Specify Language
7. Race — White ☐ Black ☐ Asian ☐
8. Ethnicity — Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address — Street or PO Box; City, State, Zip code, County
10. Marital Status — Married Widowed Separated Single Divorced
11. Number of Dependents
12. Spouse's Name
13. Doctor's Name
14. Doctor's mailing address (Street or PO Box) — City, State, Zipcode
15. Date of Injury
16. Time of Injury
17. Date Lost Time Began
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
22. Worksite Location of Injury (stairs, dock)
23. Address injury or exposure occurred, name of business — Street or PO Box, County; City, State, Zip Code
24. Cause of Injury (fall, tool, machine)
25. List Witnesses
26. Return to work date
27. Did employee die
28. Date reported
29. Supervisor's Name
30. Date of Hire
31. Was employee hired in Texas — Yes ☐ No ☐
32. Length of service in current position ______ ______
33. Length of Service in Occupation ______ ______
34. Employee Payroll Classification code
35. Occupation of injured worker
36. Rate of pay at this job
37. Full work week is ______ ______
38. Last paycheck was
39. Is Employee and owner or partner — Yes ☐ No ☐
40. Name of Person Completing Form — Phone Number
41. Name of Business
42. Business Mailing Address — City, State, Zip Code
43. Business Location — Number and Strret: **6754 Willowbrook Park Dr #200** — City: **Houston,** State: **Tx** Zip Code: **77094**
44. Federal Tax ID Number: **75-2434073**
45. Primary SIC Code: **(4 Digit) 1799**
46. Specific SCI Code: **(4 Digit) 1799**
47. Texas Comptroller Taxpayer #: **30113834599**
48. Workers' Compensation Insurance Co: **Dallas Fire**
49. Policy Number
50. Did you request accident prevention services in the 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 ______________________________

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SUPERVISOR'S REPORT OF ACCIDENT

Employee ______________________ Social Security No. ______________

Home Address ______________ City ______________ State ______ ZIP ______

Home Phone (____)__________ Other Phone (____)__________ Relationship __________

Sex ____ Marital Status ____ Number of Minor Children ____ Speak English ____ Date of Birth ___/___/___

Occupation ______________ Hire Date ___/___/___ Length of Time in Occupation __________

Wages __________ Per __________ Department ______________

ACCIDENT INFORMATION:

Department Where Injured ______________ Occupation When Injured ______________

Date of Injury ___/___/___ Day of Injury ______________ Time of Injury __________ AM PM

Street Address Where Accident Occurred ______________________________

City ______________ County ______________ State ______ ZIP ______

What Apparently Caused Accident? ______________________________

____

State how injury occurred, what employee was doing, and what part of the body was affected ______________

____

____

____

______ Employee DID want to go to the doctor ______ Employee DID NOT want to go to the doctor

Witness(es) (Give Name, Address & Home Phone) ______________________________

____

____

THIS REPORT IS DUE WITHIN 24 HOURS OF THE ACCIDENT

Supervisor/Manager Filling Out Report ______________________________

Company Address ______________________________

City, State, ZIP ______________________________ Phone (____)__________

INSTRUCTIONS: When report is complete, forward to Corporate.
If you have questions, call (281) 398-1955

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ACCIDENT/INJURY WITNESS STATEMENT

Injured worker ____________________ Date of Injury ____________________
Name of witness ____________________ Department ____________________

Were you in the area where accident happened? ☐ Yes ☐ No
Where exactly did the accident happen? ____________________

Did you see the accident happen? ☐ Yes ☐ No
What exactly did happen? ____________________
____
____

Was it obvious that the employee was hurt? ☐ Yes ☐ No
What part of the body was injured (be specific)? ____________________
Was the employee using a tool or piece of machinery when injured? ☐ Yes ☐ No
Please describe ____________________
Have you ever heard employee complain of similar injury or illness? ☐ Yes ☐ No
Have you ever heard employee talk about on-the-job injury before? ☐ Yes ☐ No
Are you aware of any other accidents, personal or on-the-job, that this employee has had? ☐ Yes ☐ No
If so, please describe ____________________
____

Did the employee violate a known safety rule? ☐ Yes ☐ No
Did you know for a fact that employee was aware of safety rule? ☐ Yes ☐ No
Do you know if employee was ever cautioned by supervisor or anyone else about unsafe work habits? ☐ Yes ☐ No

What do you think caused the accident?

- ☐ Unguarded equipment
- ☐ Employee carelessness
- ☐ Deliberate violation of safety rule
- ☐ Another employee
- ☐ Non-employee
- ☐ Horseplay
- ☐ Poorly maintained equipment
- ☐ Pressure to work faster

What can be done to prevent a similar accident in the future? ____________________
____
____
____

Comments: ____________________
____
____

To the best of my knowledge the above questions are answered truthfully.
Sworn to me this __________ day of ____________________ 20______.

____________________ Witness Signature

____________________ Supervisor

____________________ Date

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INJURED'S STATEMENT

Name ____________________ S.S. # ____________________

Signature ____________________ Date ____________________

Witness ____________________

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MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company or any other organization, institution or person that has any medical history of the below named person suffering loss, to furnish such information and/or copies of records to any insurance companies. A copy of this authorization shall be as valid as the original. I certify that the information given by me in support of this claim is valid and correct. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereof, commits a fraudulent insurance act which is a crime.

PRINT NAME ______________________ DATE ____/____/____

SIGNATURE ______________________ SOCIAL SECURITY # ______________________

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FIRST REQUEST OF MEDICAL TREATMENT

I, ______________________ request Dr. __________________ located at ______________________________

to treat me today ____________________ as my physician of choice. I am requesting treatment for an incident

which happened on ____________________________ at ______________________________________.
Client

_____ I notified PBS Immediately and came directly to the doctors office. I have not taken any medications, controlled substances or alcohol; nor have I made any stops between the client workplace and the doctors office.

_____ I did notify my on-site supervisor. I did not notify PBS immediately. I did not come directly to the doctor's office. I have:

- _____ not used any medications, controlled substances or alcohol prior to this medical request.
- _____ used medications, controlled substances or alcohol prior to this medical request understanding it was in violation of the zero drug tolerance policy of PBS.

_____ I did not notify PBS immediately nor did I notify my on-site supervisor and I did not come directly to the doctors office. I have:

- _____ not used any medications, controlled substances or alcohol prior to this medical request.
- _____ used medications, controlled substances or alcohol prior to this medical request understanding it was in violation of the zero drug tolerance policy of PBS.

I am requesting medical treatment for an injury caused by ____
____

I am requesting medical treatment for my ____

I understand, by signature below that PBS has modified duty available to me should my doctor authorize it. I further understand, this modified duty would be in compliance with my doctor's restrictions and recommendations.

By Signature below I authorize the physician and/or clinic to release and disclose all information regarding my treatment and I further release the physician, PBS and/or clinic from any liability arising from these disclosures.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Witness Date

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RECEIPT OF ACCIDENT REPORT FORM

I, ______________________________ verify that I received a copy of the injury report for my injury sustained on ____________________. I have reviewed the information, and all is true and correct.

I hereby authorize PBS to obtain any necessary medical information pertaining to the injury that occurred on the above mentioned date.

______________________________ ____________________
Employee Signature Date

____
Name Printed

______________________________ ____________________
Witness Date

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MEDICAL TREATMENT REFUSAL

Employee Name ______________________________

Social Security # ______________________________

Date of Injury ______________________________

Site of Injury ______________________________

PBS has offered to provide me with the most expedient and quality medical care for my work related injury. At this time I do not want to see a physician.

_____ I understand by taking a drug screen, but not going to a physician at this time that should I wish to seek medical attention at a later date without prior authorization, the medical bills could be denied and I would be financially responsible. Also, my insurance benefits may be denied.

_____ I have received first aid and taken a drug screen but do not request any further medical treatment. I understand that should I wish to seek medical attention at a later date without prior authorization, the medical bills could be denied and I would be financially responsible. Also, my insurance benefits may be denied.

_____ I understand that by not going to a physician or submitting to a substance testing on the date of the injury, which is required as a condition of my employment, I have voluntarily quit and my insurance benefits may be denied.

______________________________ ______________
Signature Date

______________________________ ______________
Witness Date

______________________________ ______________
Witness Date