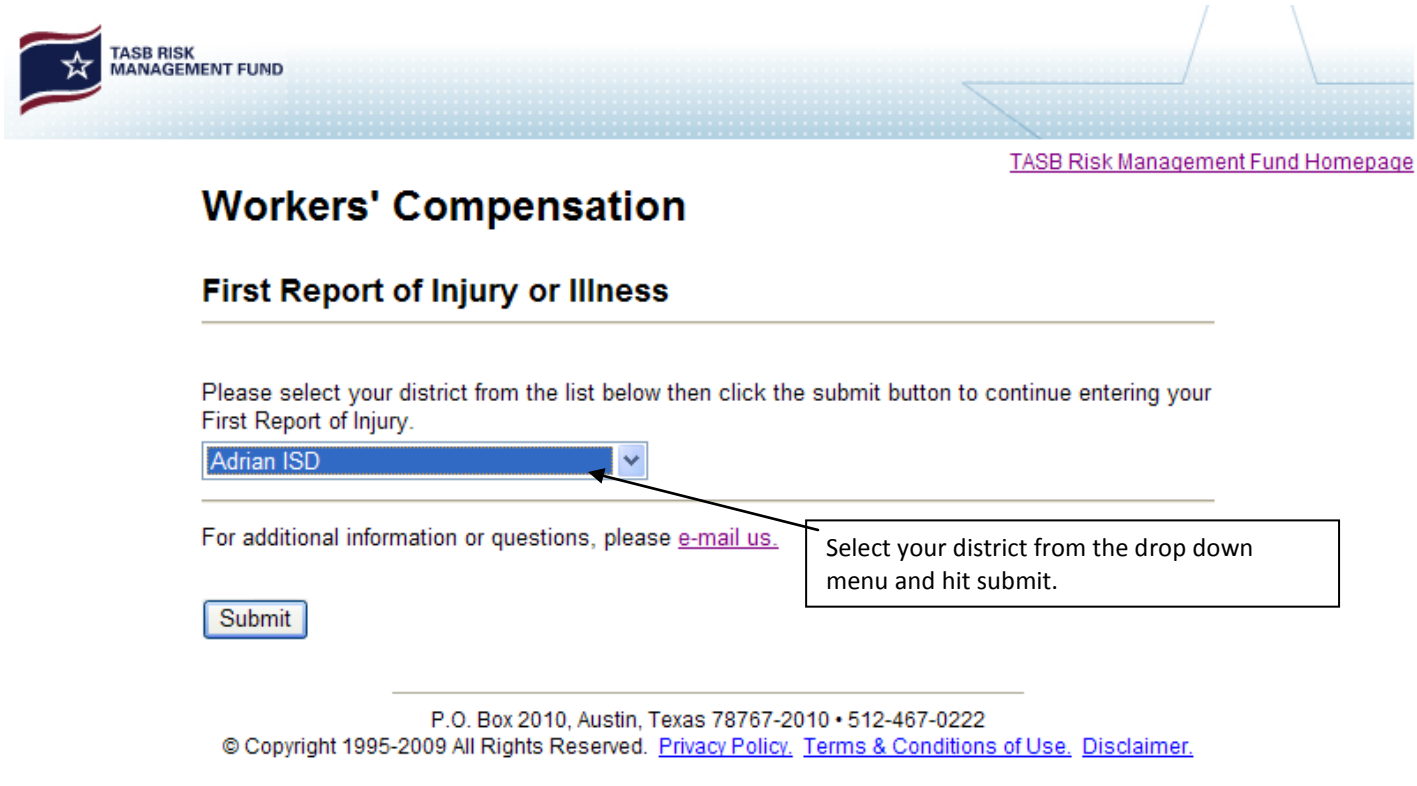
How To File A First Report of Injury



TASB RISK MANAGEMENT FUND

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

Asterisks denote required information for this report to be properly processed.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

EMPLOYER GENERAL INFORMATION

Employer Name:	Seguin ISD
Street Address Line 1:	1221 East Kingsbury
Street Address Line 2:	
City, State, Zip:	Seguin , TX 78155-2152
Mailing Address Line 1:	1221 E Kingsbury St
Mailing Address Line 2:	
City, State, Zip:	Seguin , TX 78155-2152
Tax ID Number:	7460022-87
Phone Number:	830-372-5771
SIC Code:	611110
Insured Report Number:	
Campus Code*:	ADMINISTRATION

This is for Member's who have their own numbering system. You may leave blank.

Select employee's location or campus code.

EMPLOYEE INFORMATION

Employee Name (Last, First, MI)*:

Street Address*:

Street Address:

City, State, ZIP*: TX

Phone*: - -

Date of Birth *(example: xx/xx/xxxx)*:

Social Security Number*:

Date Hired *(example: xx/xx/xxxx)*:

State of Hire: Texas

Sex*: ○ Male ○ Female ◉ Unknown

Marital Status*: ○ Unmarried ○ Married ○ Separated ◉ Unknown

Occupation/Job Title*:

Employment Status*: Apprenticeship Full-Time

# of Dependents:

Please make every effort to get employee's current mailing address. If unknown, please use 1 Unknown, Your City, Tx 11111

If unable to get current phone number, please use 111-111-1111.

If unknown, please use 01/01/1111

If unknown, please use 111-11-1111

Occupation Codes:
010 - Professional/Clerical/Administration
020 - Building Maintenance
030 - Food Service
040 - Custodial
050 - Driver & Vehicle Maintenance
060 - All Other
Example – 030/Cafeteria Cashier

Select either Regular or Part Time

WAGE INFORMATION

Rate - 0.00 :

Per*: ○ Week ○ Bi-Weekly ○ Semi-Monthly ○ Month ○ Hour ○ Daily

If rate unknown, please use 1.00

Days Worked/Week*:

Full Pay for Day of Injury? ○ Yes ◉ No

Did Salary Continue? ○ Yes ◉ No

Gross Amount of Last Paycheck - 0.00: 0

Type of Pay: ◉ Weekly ○ Bi-Weekly ○ Semi-Monthly ○ Monthly

Has employee elected to use state, sick or vacation leave in lieu of temporary income benefits? ○ Yes ○ No ◉ Unknown

If so, how many leave hours have they elected to use?

Leave this blank.

OCCURRENCE INFORMATION

Type of Claim*: ○ Record Only ○ Medical Only ○ Lost Time

Record Only – No lost time, No treatment expected, No questions
Medical Only – Currently working, no more than 3 days of lost time, no questions
Lost Time – All others

Date of Injury/Illness *(example: xx/xx/xxxx)**:

Time Employee Began Work *(example: 08:15)**: ◉ AM ○ PM

Time of Occurrence *(example: 08:15)**: ◉ AM ○ PM

Complete ONLY if employee is not at work.

Last Work Date *(example: xx/xx/xxxx)*:

Date Employer Notified *(example: xx/xx/xxxx)**:

This is the date the secretary, principal, nurse or supervisor first new of incident.

Date Disability Began *(example: xx/xx/xxxx)*:

First date of work missed due to injury. (**This is never the date of injury**.) Leave blank if there was no lost time.

Supervisor Name:

Supervisor Phone Number: - -

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Consult the code lists below. Select the code most applicable. Cuts are lacerations, bruises are contusions.

Did injury/illness exposure occur on employer's premise? ◉ Yes ○ No

Department or Location where accident or illness exposure occurred*:

Example: Reagan Elementary cafeteria or playground. If it did not occur on employer premises, enter address or location. Be sure to note if it's a different location than above.

All equipment, material or chemicals employee was using when accident or illness exposure occurred:

List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.

Specify activity the employee was engaged in when the accident or illness exposure occurred*:

Activity when accident occurred such as cooking, teaching, walking, etc.

Work process the employee was engaged in when accident or illness exposure occurred:

The work process employee was doing such as teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill*:

How injury occurred or was reported by employee. Be short and to the point. Clarify body part and side of body, ex. "Student bit employee on right hand between thumb and index finger."

Date Returned to Work *(example: xx/xx/xxxx)*:

If Fatal, Give Date of Death *(example: xx/xx/xxxx)*:

Were Safeguards or Safety Equipment Provided? ◉ Yes ○ No

Were they used? ◉ Yes ○ No

Date employee actually returned to work. Leave blank if employee is still not working. (NO FUTURE DATES.)

TREATMENT INFORMATION

Physician/Health Care Provider Name (Last, First, MI):

Physician/Health Care Provider Street Address:

Physician/Health Care Provider City, State, ZIP:

Hospital Name:

Hospital Street Address:

Hospital City, State, ZIP:

Enter doctor/hospital information if known. Not a mandatory field.

Initial Treatment*:

- ◉ No Medical Treatment
- ○ Minor by Employer
- ○ Minor Clinic/Hosp
- ○ Emergency Care
- ○ Hospitalized > 24 Hrs
- ○ Future Major Medical/Lost Time Anticipated

Mandatory

OTHER INFORMATION

Witness (Name & Phone #):

Date Administrator Notified *(example: xx/xx/xxxx)*:

Date Prepared *(example: xx/xx/xxxx)*:

Preparer's Name & Title:

Preparer's Phone Number: - -

All Other Information:

Campus e-mail address to receive confirmation:

Administrative e-mail address to receive confirmation:

Please list any witnesses known.

This is the date the location notifies Risk Management.

This area is available if more room is needed for accident description or other info.

Your email address

For additional information or questions, please e-mail us.

Submit FROI to District Administrative Office | Clear Form

When complete Submit FROI. If you've forgotten a field it will kick back. If accepted you will see a box asking if you wish to save the FROI in PDF format. Keep a copy for your records.

TASB RISK MANAGEMENT FUND

TASB Risk Management Fund Homepage

Workers' Compensation

First Report of Injury or Illness

The First Report of Injury for DOE JOHN has been submitted to TASB.

Click here to print the First Report of Injury in IA-1 Format.

(Please allow popup windows from your browser. The IA-1 form will appear in a separate window.)

Download FROI/Excel Format | Download FROI/Text Format

Return to selection screen

P.O. Box 2010, Austin, Texas 78767-2010 • 512-467-0222

Nature of Injury

01 No Physical Injury	37 Inflamation	64 Silicosis
02 Amputation	40 Laceration	65 Respirtory Disorders (Fumes)
03 Angina Pectoris	41 Myocardial Infraction	66 Poisoning-Chemical: Not Metals
04 Burn	42 Poisoning-Not OD or Cumulative	67 Metal Poisoning
07 Concusion	43 Puncture	68 Dermatitis
10 Contusion	46 Rupture	69 Mental Disorder
13 Crushing	47 Severance	71 All Other Occupation Disease
16 Dislocation	49 Sprain	72 Loss of Hearing
19 Electric Shock	52 Strain	73 Contagious Disease
22 Enucleation	53 Syncope	74 Cancer
25 Foreign Body	54 Asphyxiation	75 Aids
28 Fracture	55 Vascular Loss	76 VDT - Related Disease
29 Not Used	58 Vision Loss	77 Mental Stress
30 Freezing	59 All Other	78 Carpel Tunnel Syndrome
31 Hearing Loss or Impairment	60 Dust Disease NOC	80 All Other Cumulative Injuries
32 Heat Prostration	61 Asbestosis	90 Mulitiple Inj - Physical Only
34 Hernia	62 Black Lung	91 Multiple Inj - Physical Psych
36 Infection	63 Byssinosis	

Cause of Injury

01 Chemicals	29 Fall/Slip On Same Level	67 Strike/Step Sand, Scrape, Clean
02 Hot Objects or Substances	30 Slipped, Did Not Fall	68 Strike/Step Stationary Obj.
03 Temperature Extremes	31 Fall/Slip Miscellaneous	69 Stepping on Sharpe Object
04 Fire or Flame	32 Fall/Slip: On Ice or Snow	70 Strike/Step Miscellaneous
05 Steam or Hot Fluids	33 Fall/Slip: On Stairs	74 Struck/Injured: Fellow Worker
06 Dust, Gases, Fumes or Vapors	40 Crash of Water Vehicle	75 Struck/Injured: Falling Object
07 Welding Operations	41 Crash of Rail Vehicle	76 Struck/Injured: Tools
08 Radiation	45 Collision With Another Vehicle	77 Struck/Injured: Vehicle
09 Burn: Miscellaneous	46 Collision With Fixed Object	78 Struck/Injured: Moving Machine
10 Caught In/Between Machine(ry)	47 Crash of Airplane	79 Struck/Injured: Obj. Lifted
11 Cold Objects or Substances	48 Vehicle Upset	80 Struck/Injured: Obj. HDLD. OTH
12 Caught In/Between Obj. Handled	50 Motor Vehicle Miscellaneous	81 Struck/Injured:Miscellaneous
13 Caught In/Between/Under, NOC	52 Strain/Injury: Continual Noise	82 Absorbed/Ingested/Inhaled NOC
14 Abnormal Air Pressure	53 Strain/Injury: Twisting	84 Contact With Electric Current
15 Cut/Scrapr by Broken Glass	54 Strain/Injury: Jumping	85 Animal or Insect
16 Cut/Scrape by Hand Tool	55 Strain/Injury: Hold or Carry	86 Explosion or Flare Back
17 Object Being Lifted or Handled	56 Strain/Injury: Lifting	87 Foreign Body in Eye
18 Cut/Scrape Power Tool	57 Strain/Injury: Push or Pull	89 Person in Act of a Crime
19 Cut/Scrape Miscellaneous	58 Strain/Injury: Reaching	90 Not a Physical Cause of Injury
20 Collapsing Materials	59 Strain/Injury: Using Tool/Mach	94 Rubbed/Abraded:Repetitive Motion
25 Fall/Slip From Diff. Level	60 Strain/Injury: Miscellaneous	95 Rubbed/Abraded: Miscellaneous
26 Fall/Slip From Ladder/Scaffold	61 Strain/Injury: Wield or Throw	97 Strain/Injury: Repetitive Motion
27 Fall/Slip From Grease/Liquid	65 Strike/Step Moving Parts	98 Cumulative (All Other)
28 Fall/Slip: Into Openings	66 Strike/Step Obj Lifted/Used	99 Other

Body Part Injured

10 Multiple Head Injury	32 Elbow	51 Hip
11 Skull	33 Lower Arm	52 Upper Leg
12 Brain	34 Wrist	53 Knee
13 Ear(s)	35 Hand	54 Lower Leg
14 Eye(s)	36 Finger(s)	55 Ankle
15 Nose	37 Thumb	56 Foot
16 Teeth	38 Shoulder(s)	57 Toe(s)
17 Mouth	39 Wrist(s) and Hand(s)	58 Great Toe
18 Soft Tissue: Head	40 Multiple Trunk	60 Lungs
19 Facial Bones	41 Upper Back Area (Thoracic)	61 Abdomen Including Groin
20 Multiple Neck Injury	42 Lower Back (Lumbar/Lumbo-Sacral)	62 Buttocks
21 Neck Vertebrae	43 Disc: Trunk	63 Lumber and or Sacral Vertebra
22 Neck Disc	44 Chest, Ribs, Sternum, Soft Tissue	64 Artificial Appliance
23 Spinal Cord (Neck)	45 Sacrum and Coccyx	65 Insufficient Info to Identify
24 Larynx	46 Pelvis	66 No Physical Injury
25 Soft Tissue: Neck	47 Spinal Cord	90 Multiple Body Parts
26 Trachea	48 Internal Organs	91 Body Systems-Single and Multiple
30 Multiple Upper Extremities	49 Heart	99 Whole Body Impairment
31 Upper Arm, Clav. Scapula	50 Multiple Lower Extremities	