____
Date

Under the Texas Labor Code, the patient, ________________________________ is identified as an employee of the Texas A&M Forest Service and is currently deployed as a member of an All-Hazard Incident Management Team or Texas Intrastate Fire Mutual Aid System. They are seeking treatment related to an on the job injury and is being filed as a Workman's Compensation claim. Please submit claim information to:

State Office of Risk Management (SORM)
P.O. Box 13777
Austin, TX 78711-3777

Additional SORM contact information:

www.sorm.state.tx.us
Main – 877-445-0006
Fax – 512-370-9025

Our members have been instructed not to provide any personal insurance information. In order to avoid any out of pocket expenses, please ensure the claim is filed accordingly for workman's compensation at the initial time of treatment.

We greatly appreciate your efforts during this time. If you have any questions please allow 72 hours for us to submit the necessary paperwork to the TFS Safety Office. After that time if you have questions and SORM is not able to assist, please contact the TFS Safety Officer at (979) 458-6697 or Safety@tfs.tamu.edu.

TFS Accident Investigation Report

Section 1. ***To be completed by Incident Supervisor. Forward to your TFS IRD Agency Representative and TFS Environmental Health & Safety Officer no later than 24 hours after the accident/incident.***

Name: Accident Date & Time:

Supervisor Name:

Incident:

Incident (check all that apply)

Near Miss | Injury | Illness | Property Damage | Theft | Fire

Motor Vehicle Accident | Environmental Release | Other (Describe):

Location/Area Occurred:

Incident Description *(if additional space is needed, attach separate page with incident description)*:

*****RECOMMEND COMPLETING ELETRONICIALLY FOR FINAL SUBMISSION*****
(some sections auto fill later in document)
Electronic Signatures or Original Signatures are accepted

Section 2. ***To be completed by Lead Accident Investigation Official. Copy to your TFS IRD Agency Representative and TFS Environmental Health & Safety Officer no later than ten (10) working days after the incident.***

Cause #1 Root/Primary Cause Causal Contributing Cause Category Number (refer to section 4) If Causal Category Number is "other," explain:	Individual Responsible for Correction Action:
Recommended Corrective Action:	Corrective Action Completion Date (m/dd/yy):
Cause #2 Root/Primary Cause Contributing Cause Causal Category Number (refer to section 4) If Causal Category Number is "other," explain:	Individual Responsible for Correction Action:
Recommended Corrective Action:	Corrective Action Completion Date (m/dd/yy):
Cause #3 Root/Primary Cause Contributing Cause Causal Category Number (refer to section 4) If Causal Category Number is "other," explain:	Individual Responsible for Correction Action:
Recommended Corrective Action:	Corrective Action Completion Date (m/dd/yy):

Section 2 (continued)					
Involved Equipment & Tools Analysis				**Procedure Issues**	
Check Box	***If primary/root cause or contributing cause for the incident was due to an equipment or tool problem, please indicate below.***	***Specify Equipment Numbers (when possible)***		***Check Box***	***If the primary/root cause or contributing cause for the incident was due to a procedure problem, please indicate the procedure.***
	Piping, hoses, valves and fittings				Lockout/Tag out
	Pumps, compressors				Confined Space Entry
	Company trucks-forklift, tractors, trailers, fleet vehicles, rental vehicles, etc.				Hot Work
	Hoists, cranes, etc.				Hazardous Communications
	Portable equipment, machinery				Fall Protection
	Ladders, scaffolds				
	Electrical distribution equipment				
	Floors, working/walking surfaces, stairs				
	Tools–hand (wrenches, knives, etc.)				
	Tools–powered (electric, air, etc.)				

Complete this section only if the event involved an Environmental Incident

Type of Incident: Air Release Spill Waste Water Excursion Other (describe):

Did Release Reach: Open Ground Creek/River Outside Field Country Ditch

Other (describe):

Date/Time Release Started (mm/dd/yyyy): Ended (mm/dd/yyyy):

Specific Fuels Involved: Fuel Name Gallons Where Released:

Air Water Ground

Air Water Ground

Environmental Notified: Date/Time (mm/dd/yyyy:hh:mm AM/PM)

Name of Reporting Person:

Section 3. *Submit with Section 2.*

Lead Accident Investigation Official Name (Print):

Job Title:

Accident Investigation Team Members (Print):

-
-
-
-

Recommended Action:

Accident Investigation Team Member Signatures:

______________________________________ ______________________________________

______________________________________ ______________________________________

TFS IRD/Field Liasion Signature

Date (mm/dd/yy):

______________________________________ ___________________________

The cause of the accident has been determined to be:

Unsafe Condition(s) Unsafe Behavior(s) Both Lost Time Case # of Days Lost: ____________

Division Director Comments or Additional Recommended Actions:

Division Director Signature:

______________________________________ Date: ___________________________

Copy completed form to TFS IRD Agency Representative and TFS Environmental Health & Safety Officer no later than ten (10) business day after incident.

Causal Category & Corresponding Numbers Table–*Refer to this table to obtain Causal Category Numbers.* ***First****, determine "Causal Category(ies)" in left-hand column below.* ***Second****, look under "Cause subcategory(ies) and determine selection(s).* ***Third****, determine "Corresponding Cause Category Index Numbers."* ***Fourth****, enter "Cause Category Index Numbers" in appropriate box of Section 2 of this form.*

Cause Category	Cause Subcategory	Corresponding Cause Category Index Numbers	
People	Rules Known but not used	(A1) Because it was not thought to be required	(A2) Because it was not convenient to use
		(A3) Because the risk was deemed acceptable	(A4) Because of poor judgment
	Training less than adequate	(B1) Because training was not given	(B2) Because task analysis was less than adequate
		(B3) Because task was infrequently performed	(B4) Because training was incomplete
		(B5) Because continuing training was less than adequate	
	Lack of attention/ concentration	(C1) Because of preoccupation with another task	(C2) Because of fatigue
		(C3) Because of distraction	(C4) Because of attitude
	Inadequate Communications	(D1) Because standard terminology was not used	(D2) Because of noisy environment
		(D3) Because message was not complete	(D4) Because information was not specific to task
		(D5) Because of time constraints	(D6) Because events happened too fast
		(D7) Because shift relief was incomplete	
	Management Programs less than adequate	(E1) Because accountability was not defined	(E2) Because corrective actions were not implemented
		(E3) Because planning was less than adequate	(E4) Because scheduling was less than adequate
		(E5) Because authority was not clearly defined	(E6) Because of a lack of management direction
		(E7) Because of management interference in task	(E8) Because too many concurrent tasks assigned
		(E9) Because of less than adequate resource management	
	Other	(F1)	
Procedures	Procedure was never written	(G1) Because it was not approved	(G2) Because it was not thought to be required
	Procedure was incorrect	(H1) Because sequence of steps was wrong	(H2) Because information was incorrect
		(H3) Because document changes were not clear	
	Procedure was incomplete or less than adequate	(I1) Because the format was confusing	(I2) Because of more than one action per step
		(I3) Because it did not cover the situation	(I4) Because the instructions were ambiguous
		(I5) Because the document was not legible	(I6) Because document changes were not clear
	Procedure not enforced	(J1) Because accountability not defined	(J2) Because consequences are deemed acceptable
	Other	(K1)	
Equipment/ Environmental	Design Deficiencies	(L1) Because the labeling was not adequate	(L2) Because of bad lighting
		(L3) Because of noisy environment	(L4) Because the problem was not anticipated
		(L5) Because design review failed to detect errors	(L6) Because the ergonomics were poor
	Manufacturing Deficiency	(M1) Because incorrect standard applied	(M2) Because of material deficiencies
		(M3) Because of lack of proper tools	(M4) Because of inadequate process
	Installation Deficiency	(N1) Because not installed per design	(N2) Because a temporary device was not removed
	Work Environmental	(O1) Because of environmental conditions (i.e., rain, ice, wind, insect bites, etc.)	
	Other	(P1)	

THIS PAGE AUTOFILLS FROM SECTION 1

Incident Description (The entire incident description appears on this page. Only a portion of the description will appear on Page 1 of this form):

THIS PAGE AUTOFILLS FROM SECTION 2

Cause #1, Recommended Corrective Action:

Case #2, Recommended Corrective Action:

Cause #3, Recommended Corrective Action:

Supplemental Witness Statement
For First Report of Injury

Claimant: ________________________________ Claim Number: __________________

Statement of:

SUPERVISOR ☐

WITNESS ☐

It appears that your co-worker referenced above was involved in a work-related injury on _____ at or about _____ am/pm receiving a _____. Please answer the questions listed below as your witness statement and return to the Office or Risk Management & Safety.

Describe in your own words what happened and what you observed. (Be as specific as possible)

Describe what part of the body you observed to be injured.

_____________________________________ ____________________

Signature Date

Print Name: __________________________________

Address: _____________________________

____

____

Phone: __________________

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' 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 filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' 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 filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.

Item 4: If no home phone, please provide a phone number where the employee can be reached.

Items 5,15,17, 26,29,30: Enter data in month, day, year format. Example: 08-13-54.

Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.

Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.

Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.

Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.

Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.

Items 32,33: Enter date in month-year format. Example: 02-56.

Item 37: Enter the number of days or hours that make up a full work week for your employees.

Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.

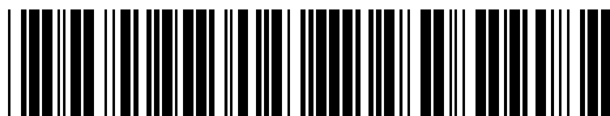
Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Item 3: ONLY fill out the last four (4) of your Social Security Number (SSN)

Item 13: Treating Physician

Item 25: Submit Statements from each Witness

Items 30-51: DO NOT FILL OUT



Send the specified copies to your Workers' 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 ☐
3. Social Security Number - -
4. Home Phone ( )
5. Date of Birth (m-d-y) - -
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name **Treating Physician**
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 ☐ pm ☐
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 ☐ NO ☐
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 **Submit Statements - Form TFS WC-1**
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) - -

******* LEAVE SECTION BELOW BLANK INCLUDING SIGNATURE *******

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 ( )
City State Zip Code
43. Business Location (If different from mailing address)
Number and Street
City State Zip Code
44. Federal Tax Identification Number
45. Primary North American Industry Classification System Code: (6 digit)
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 ______________

****Response Member Does NOT sign (TFS Safety Officer Signature Required)****