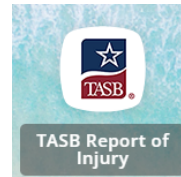


How to File a First Report of Injury

Campus or Department Instructions

Start at <https://www.tasbrmf.org/claims/report-a-claim>



TASB RISK FUND

RISK SOLUTIONS & SERVICES ▾

COVERAGES ▾

CLAIMS ▾

TRAINING & EVENTS

RESOURCES ▾

ABOUT ▾

Report a Claim

Fund members can report workers' compensation, auto, liability, property, and cyber claims 24/7.

[Home](#) > [Claims](#) > [Report a Claim](#)

If you need immediate assistance, please call 800-482-7276. Calls are answered 24/7. Any calls made after business hours or on weekends will be returned by an adjuster within an hour.

Workers' Compensation First Report of Injury

Use this option to report a claim if you are a:

- Program administrator who does not use the FROI Administration application
- Campus or department employee who needs to report an employee injury to your organization's workers'

Type **KATY ISD** into the search bar and select. Then, click Report a Claim.

Workers' Compensation First Report of Injury

Enter your Organization Name to get started

Katy ISD

REPORT A CLAIM

What you will need:

- Basic information about what happened, including date, location, etc.
- Additional details about the employee who was injured, such as name, address, and wage information

What you should know:

- The reporting form will timeout after 120 minutes of inactivity.
- You can find detailed instructions on how to report a workers' compensation claim [in this guide](#).

When you are finished filling out the First Report of Injury (FROI) on the next page, be sure to click on the "Complete Incident" button at the top of the page to submit to your TASB FROI Administrator.

[Start a FROI](#)

Click here to get started.

Please note that all boxes marked with a red asterisk (*) are **mandatory**. As you work on the form, ensure all required boxes are completed and contain correct information.



New First Report of Injury

Employer General Information

Member Education ISD

Physical Address 123 1st Street
City Your City
State Texas
ZIP 00000

FEIN 12345678
Phone (123) 456 7890

Mailing Address PO Box 123
City Your City
State Texas
ZIP 00000

Is this a corrected copy? *

Select "Yes" if you have already submitted a claim for this incident and need to update any information or if you are submitting a FROI on an already-created claim.

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

Click on the magnifying glass to select the applicable location from the list.

If the injury occurred off campus, select "No" and enter the address of the injury in a box that will appear to the right.

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

Address where Injury/Illness Occurred ⓘ

Since you selected Injury did not occur on employer's premises, please complete the accident address fields to the right.

Employee Information

First Name: *	<input type="text"/>
Middle Name:	<input type="text"/>
Last Name: *	<input type="text"/>
Street Address 1: *	<input type="text"/>
Street Address 2:	<input type="text"/>
City: *	<input type="text"/>
State: *	<input type="text" value="Texas"/>
ZIP: *	<input type="text" value="##### -####"/>
Phone: *	<input type="text" value="(xxx) xxx-xxxx"/>
Work Phone:	<input type="text" value="(xxx) xxx-xxxx"/>
Employee Email:	<input type="text"/>
Does the employee speak English?	<input type="text" value="- None Selected -"/>

Please enter the employee's first and last name.

Please enter the employee's correct mailing address and contact info. Enter the number 1 if you do not know the information.

Birth Date *

01/01/2010



Social Security ⓘ *

111-11-1111

Other Employee ID

Other Employee ID Qualifier

Hire Date *

01/01/2010



Length of Service Years

0

Length of Service Months

Hire State *

Texas

Gender *

Not Specified

Marital Status *

Unknown

Occupation/Job Title *

Teacher

Payroll Class Code *

PROFESSIONAL/ADMINISTR

Occupation Code *

PROFESSIONAL/CLERICAL/

Department Code, if applicable

Employment Status *

Regular/Full-time Employee

Number of Dependents

Please complete all required fields.

Complete correct job title, occupation code, and payroll codes are entered.

Please select either regular or part-time.

Wages

Wage Rate *

1.00

Wage Rate Type ⓘ *

Daily

Days Worked Per Week *

5

Hours Worked Per Week

Full Pay On Day Of Injury

Yes

Did Salary Continue?

Please complete all mandatory wage fields. Enter the number 1 if you do not know the information.

Gross Amount of Last
Paycheck

Type of Pay ⓘ

Has employee elected to use
state, sick or vacation leave in
lieu of temporary income
benefits?

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

Complete all mandatory
wage information fields
with accurate information.

Occurrence Information

Date of Injury/Illness *

10/20/2020



Time Employee Began Work

12:00PM

Time of Injury or Illness

10:00 PM

Exposure *

Date Employer Notified *

10/20/2020



Has the employee lost time or
expected to lose time from
work?

Was the injury or illness
exposure fatal?

Employee's Supervisor

Supervisor Phone Number

(xxx) xxx-xxxx

Type of Injury/Illness *

Contusion



Part of Body Affected *

Knee



Cause of Injury *

Fall, Slip, or Trip - Liquid or Grease



Enter the correct time
and date of injury.

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

Click the magnifying glasses to
select the employee's injury,
affected body part, and cause of
injury from the lists. You can also
type the employee's injury/body
part or its corresponding code
number into the search bar and
select from the dropdown lists.

Note: These are national,
standardized codes. Choose the
option that best matches your
incident.

Examples include walking, cleaning, or cooking.

Worksite location of injury ⓘ

Was employee doing their regular job?

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

Walking through hallway

How did the injury or illness exposure occur? ⓘ *

Slipped in puddle and fell on left hip

For example, employee slipped on wet floor in hallway while walking and fell on both knees

Is the employee seeking or expected to seek medical treatment? *

Yes

Type of Claim ⓘ *

Medical Only

Explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** This space is limited and info entered should show on the completed DWC1/FROI.

Record Only is for no medical treatment, no lost time, and no questions or concerns.

Medical Only is for initial medical and/or no more than 5 days of lost time.

Lost Time/Indemnity is for ongoing medical treatment and/or lost time and all other.

Treatment Information

Medical Provider

Physician/Hospital Name

Address

City

State

ZIP

Phone

Fax

#####

(xxx) xxx-xxxx

(xxx) xxx-xxxx

Initial Treatment *

Minor clinic/hospital medical re ▼

Enter doctor/hospital information, if known. These are not mandatory fields.

This field is mandatory. Select the appropriate option from the dropdown list.

Other Information

Date Administrator Notified

Date Prepared *

Preparer's Name *

Preparer's Title *

Preparer's Phone *

E-mail address to receive confirmation

This is the date the campus notifies Risk Management.

Witness

Witness Phone #

All Other Information

Please list any known witnesses and their contact information. Do not include student names.

You can use this field to add additional information.

Do you intend to submit FROI to TASB at this time? *

Click No.

Apps | Site | AMS | TASB Online | Sharepoint | ShareBase | CompSuite | OWC Rules | live.orgamirisk.com says

Member Participat... | GoToMeeting Hub | AMS | TASB Library | Bookings | Other bookmarks

New First Report of Injury

Are you ready to complete this incident?

Employer General Information

Member	Abbott ISD
Physical Address	219 S First St
City	Abbott
State	Texas
ZIP	76621
FEIN	746000001
Phone	(254) 582-3011

Is this a corrected copy?

Insured Report Number

Location *

Did injury or illness exposure occur on employer's premises?

Member Address

PO Box 226
Abbott
Texas
76621-0226

After you've filled out the required fields, click Complete to submit your FROI.

Click Ok

Upload Claim File Documentation

Save Successful

Please upload any relevant documentation such as videos, photos, passenger lists, police reports, damage estimates, medical, or legal notices. Otherwise, you've provided enough information for us to begin processing. Click I'm done below to finish reporting your claim. If submitting a First Report of Injury (FROI), it has been sent to your TASB FROI Administrator for review. To download a copy of the FROI, use your browser's refresh button to display a link.

#1 Doe, John (EV2020004582-1)

No files uploaded.

or [Click here to exit](#)

Congratulations! You have successfully completed your FROI.

Your FROI will look like this. Click on the icons to print or save to your computer for your records. If you do not receive an emailed copy, please contact Risk Management.

DWC001



Complete if known:

DWC claim #

Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last) Jane Doe		2. Address (street or PO box, city, state, ZIP code) 6301 South Stadium Lane , Katy, Texas 77494	
3. Phone number (281) 396-2212	4. Email address	5. Social Security number XXX-XX-1111 (XXX-XX-XXXX)	6. Date of birth (mm/dd/yyyy) 12/13/1985
7. Marital status Married		8. Sex <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	
9. Spouse's name (first, middle, last)		10. Number of dependent children	
11. Does the employee speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, specify language			
12. Doctor's name (first, last) Memorial Hermann Occupational		13. Doctor's mailing address (street or PO box, city, state, ZIP code) 23920 Katy Fwy #540 Katy Texas 77493	

For any questions about reporting a Workers' Compensation Claim, please contact Risk Management at 281-396-2241.