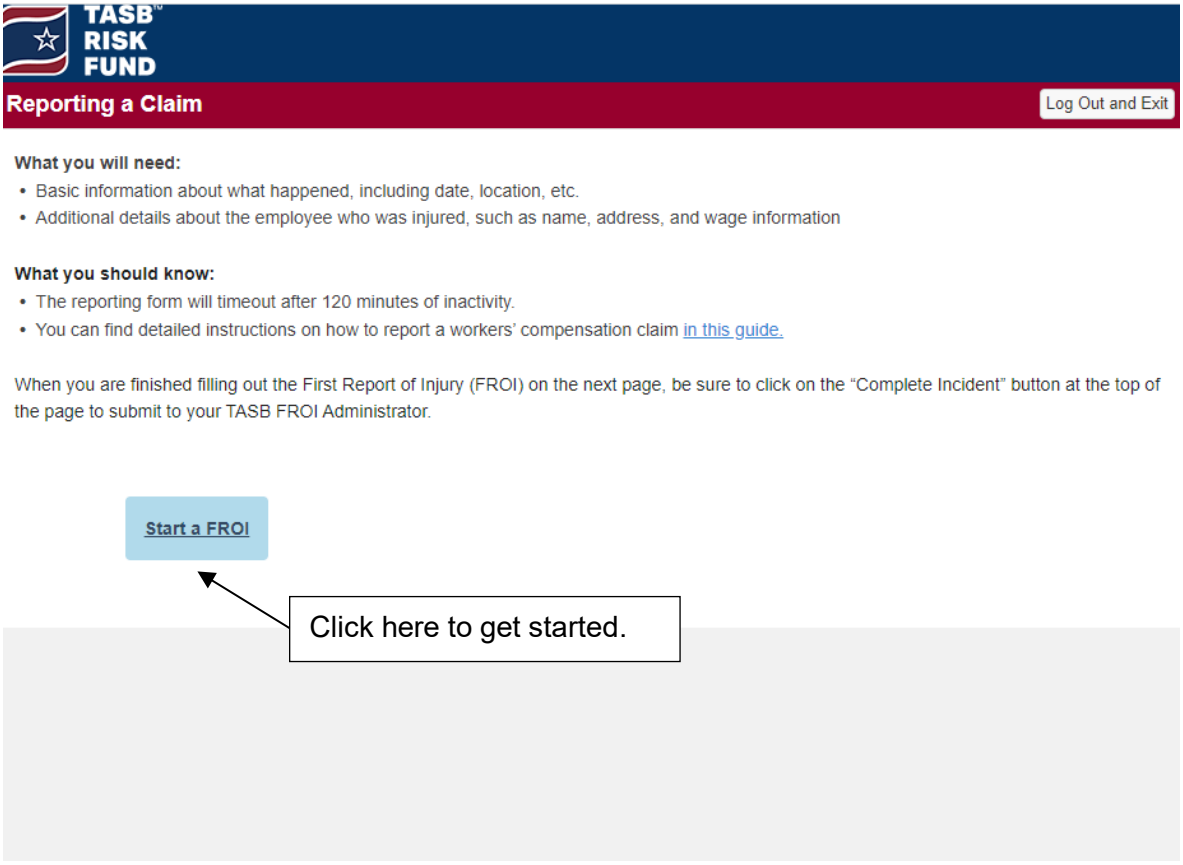
How to File a First Report of Injury

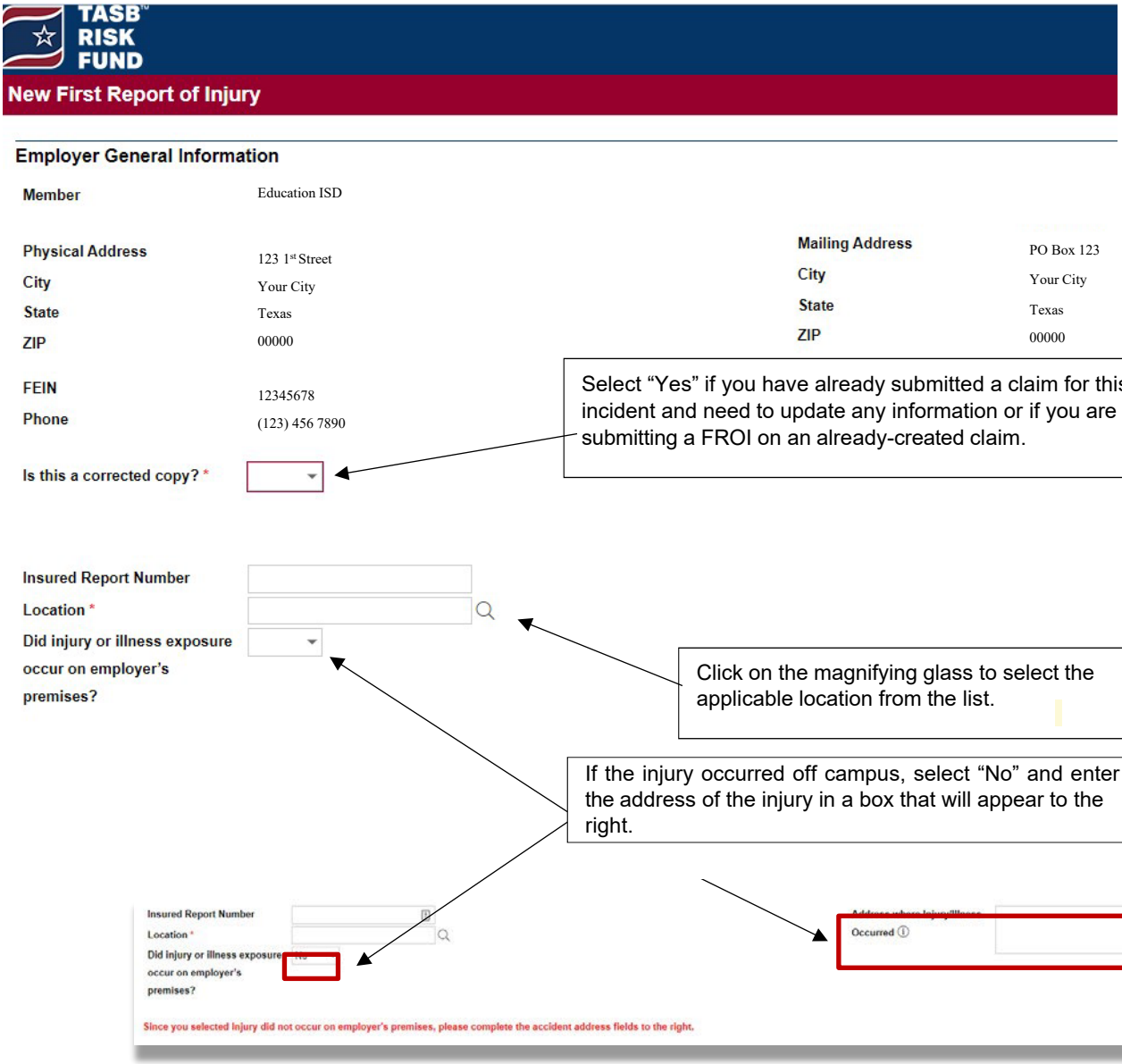
Campus or Department Instructions

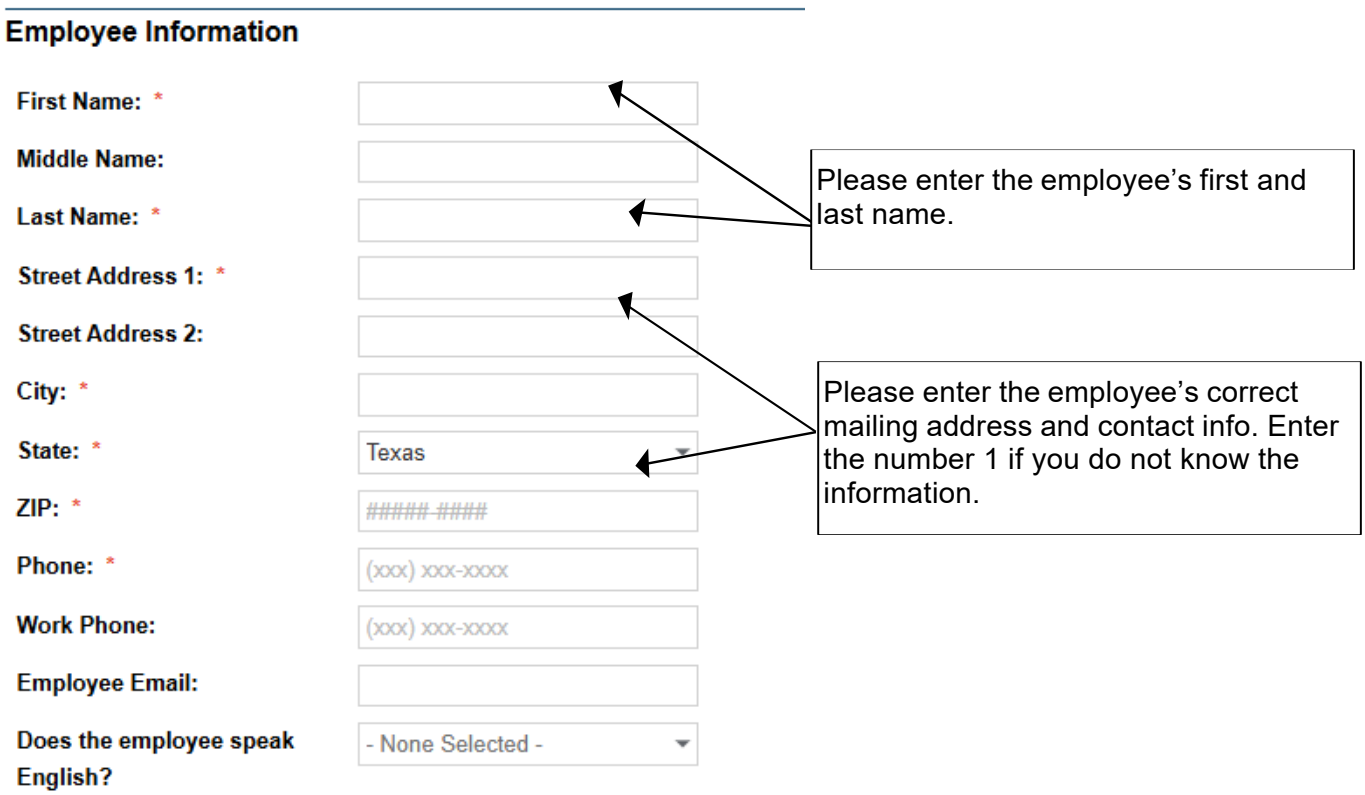
Start at https://www.tasbrmf.org/claims/report-a-claim

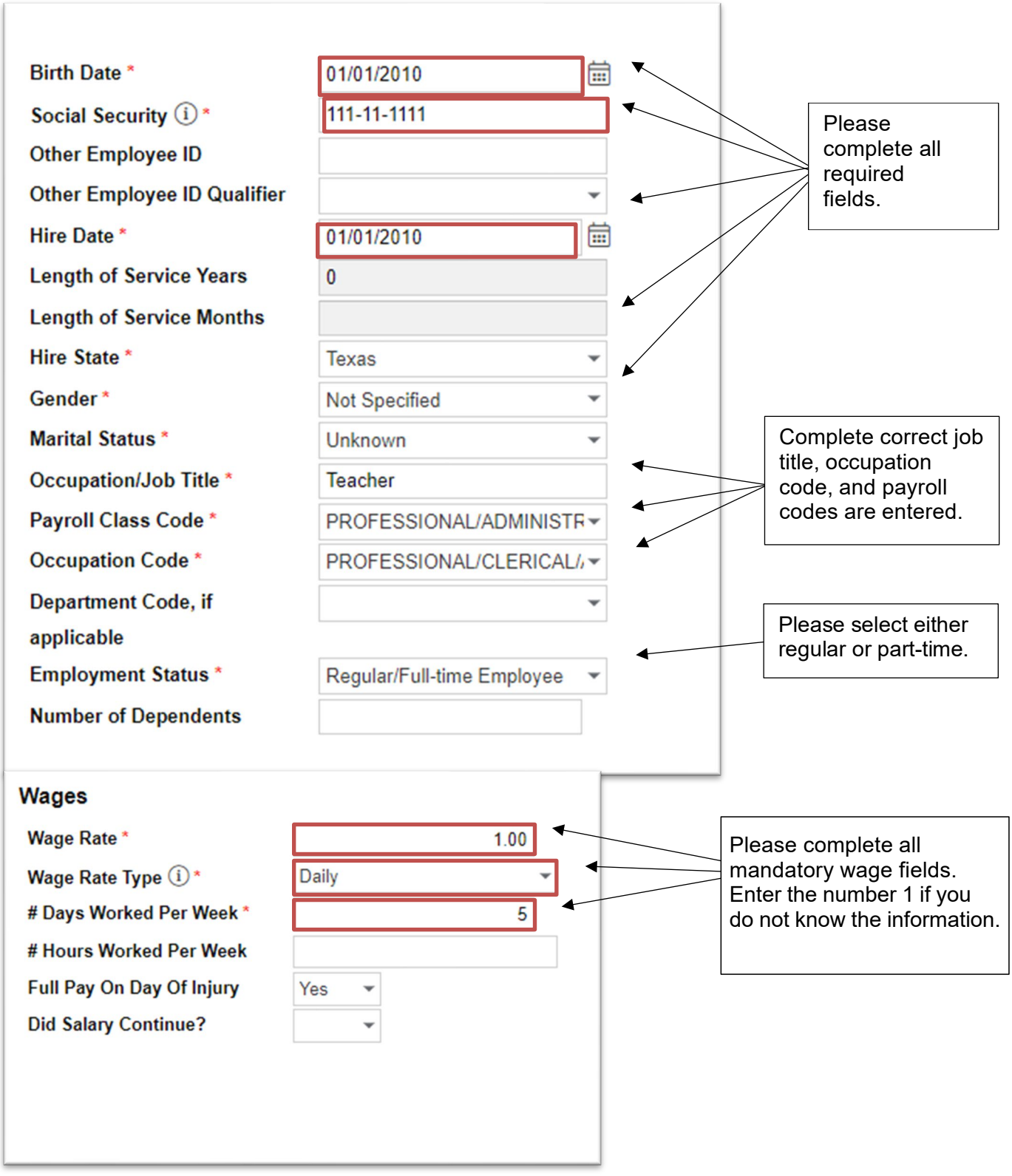
Type **KATY ISD** into the search bar and select. Then, click Report a Claim.

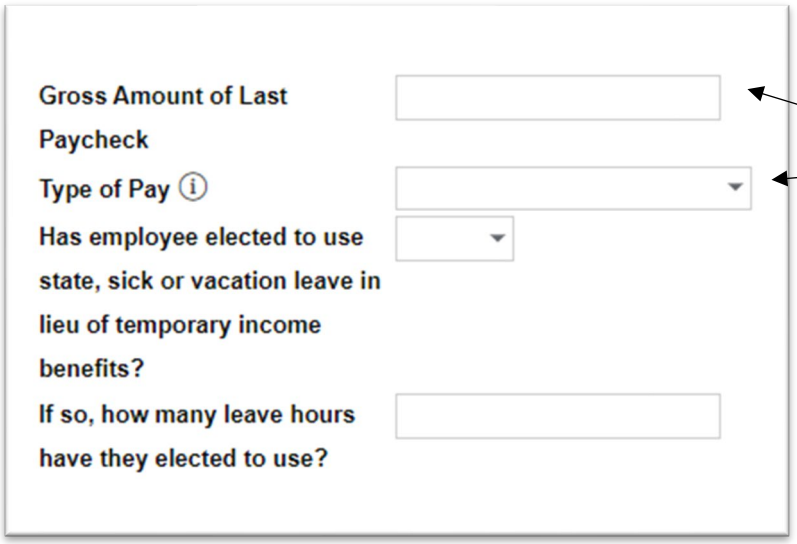


Please note that all boxes marked with a red asterisk (*) are **mandatory**. As you work on the form, ensure all required boxes are completed and contain correct information.

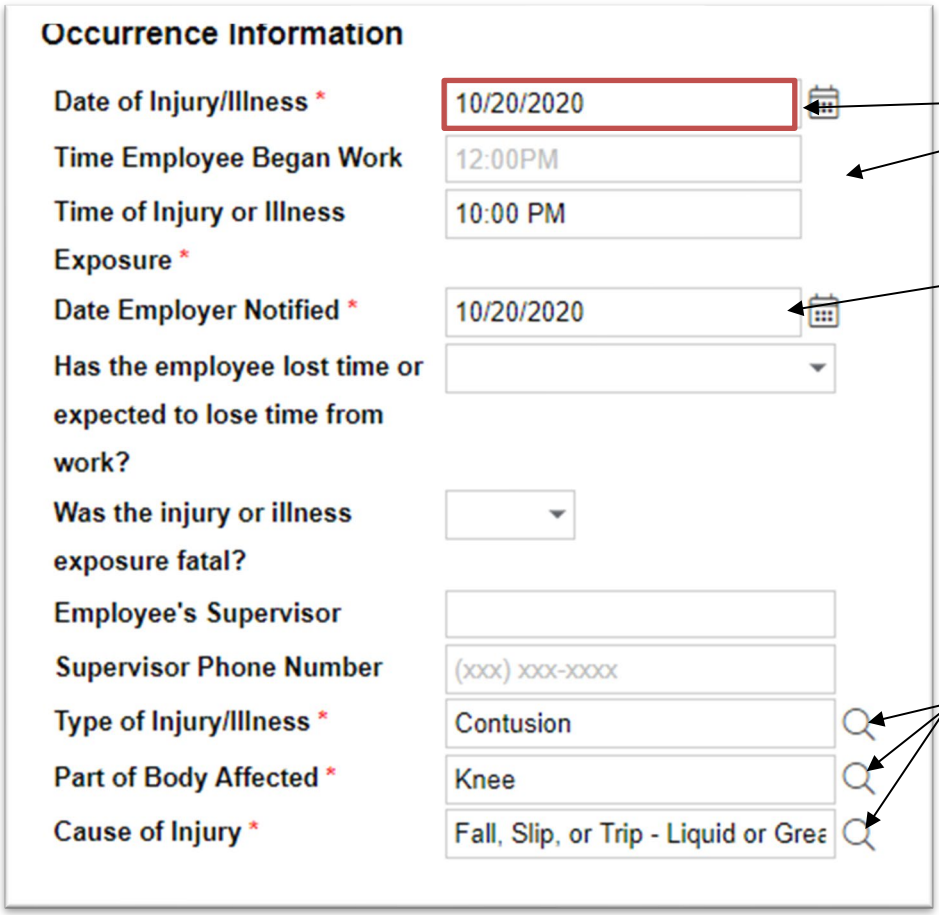

TASB RISK FUND
New First Report of Injury
Employer General Information
Member
Education ISD
Physical Address
123 1st Street
City
Your City
State
Texas
ZIP
00000
Mailing Address
PO Box 123
City
Your City
State
Texas
ZIP
00000
FEIN
12345678
Phone
(123) 456 7890
Is this a corrected copy? *
Select “Yes” 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?
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: *
Middle Name:
Last Name: *
Street Address 1: *
Street Address 2:
City: *
State: *
Texas
ZIP: *
####
Phone: *
(xxx) xxx-xxxx
Work Phone:
(xxx) xxx-xxxx
Employee Email:
Does the employee speak English?
- 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.



Complete all mandatory wage information fields with accurate information.

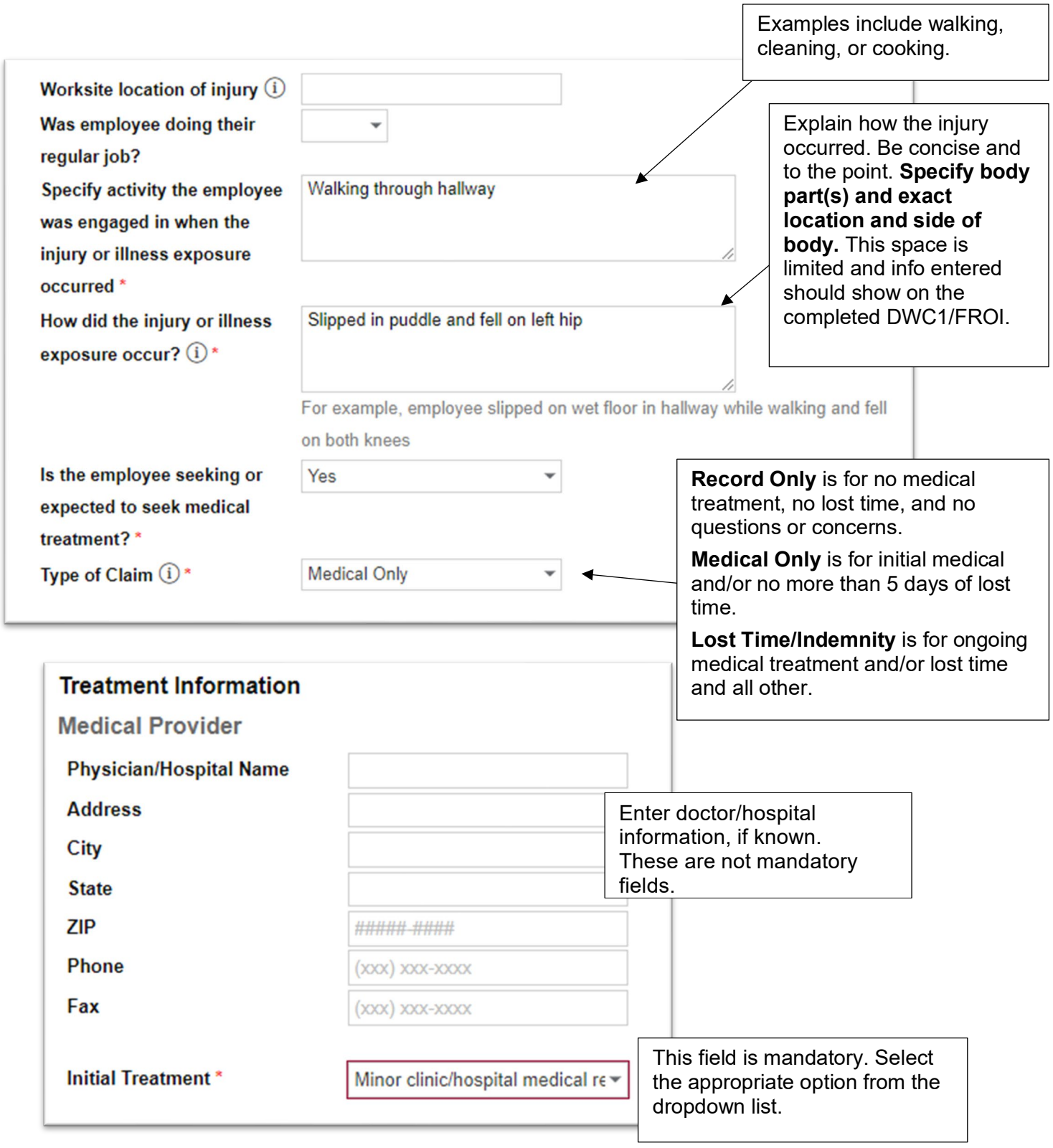


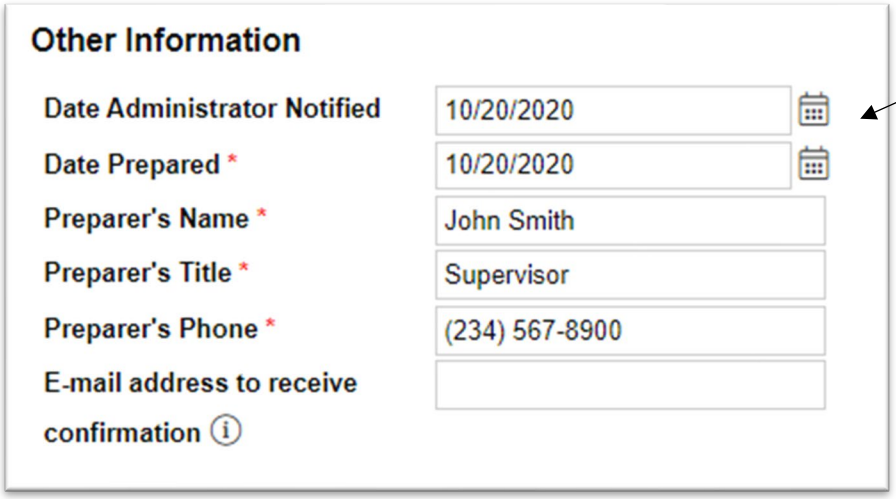
Enter the correct time and date of injury.

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.
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.
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
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
(xxx) xxx-xxxx
Fax
(xxx) xxx-xxxx
Enter doctor/hospital information, if known. These are not mandatory fields.
Initial Treatment *
Minor clinic/hospital medical re
This field is mandatory. Select the appropriate option from the dropdown list.

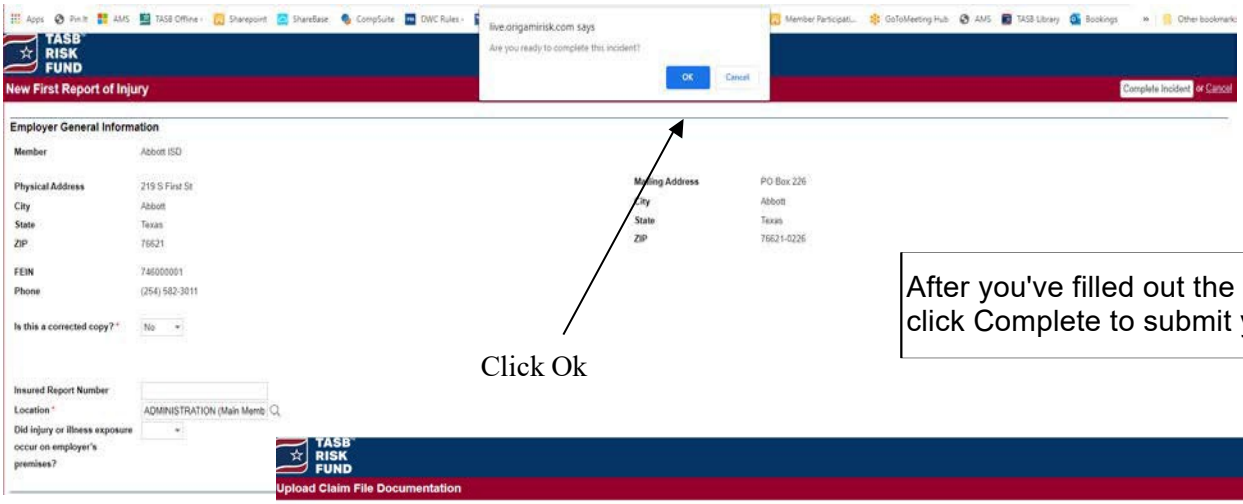


This is the date the campus notifies Risk Management.

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

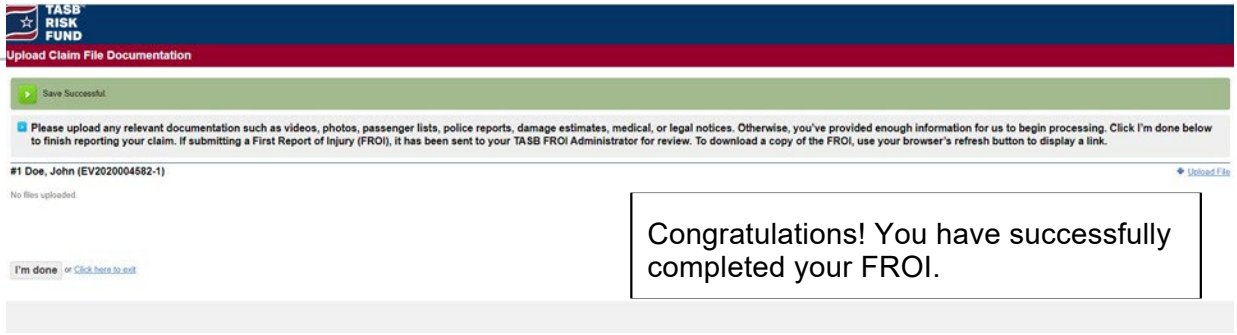
You can use this field to add additional information.

Click No.



Click Ok

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



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

TDI Division of Workers' Compensation

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

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