

# Cómo presentar un Primer Reporte de Lesión

Esta guía es para miembros que no usan la aplicación de Administración FROI.

Comience aquí: <https://www.tasbrmf.org/claims/report-a-claim>



TASB RISK FUND

RISK SOLUTIONS & SERVICES

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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' compensation program administrator

#### Workers' Compensation First Report of Injury

Enter your Organization Name to get started

Katy ISD

REPORT A CLAIM

Escriba **KATY ISD** en el buscador y **seleccione**. Luego haga clic en Report a Claim (Informar un reclamo WC)

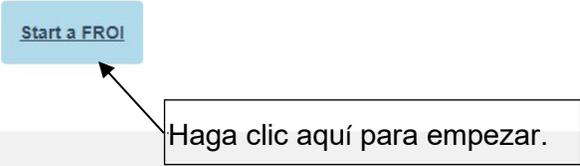
**What you will need:**

- 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

Haga clic aquí para empezar.

Todos los cuadros marcados con un asterisco (\*) **son obligatorios**. Al completar el formulario, asegúrese de que todos los cuadros requeridos estén completos y que contengan la información correcta.



### New First Report of Injury

#### Employer General Information

Member Education ISD

Physical Address 123 1<sup>st</sup> 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

Marque "Yes" si ya presentó su reclamo para este incidente y necesita actualizar información o si está presentando un FROI en un reclamo ya creado.

Is this a corrected copy? \*

Insured Report Number

Location \*

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

Haga clic en la lupa para seleccionar una ubicación aplicable de la lista.

Si la lesión ocurrió fuera del campus, seleccione "No" e ingrese la dirección donde ocurrió la lesión en el cuadro que aparecerá a la derecha.

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.

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## Employee Information

First Name: \*

Middle Name:

Last Name: \*

Street Address 1: \*

Street Address 2:

City: \*

State: \*

ZIP: \*

Phone: \*

Work Phone:

Employee Email:

Does the employee speak English?

Ingrese el nombre y apellido del empleado en estos cuadros.

Ingrese la dirección de correo e información de contacto correcta del empleado. Ingrese el número 1 si desconoce dicha información.

**Birth Date \***    
**Social Security ⓘ \***   
**Other Employee ID**   
**Other Employee ID Qualifier**   
**Hire Date \***    
**Length of Service Years**   
**Length of Service Months**   
**Hire State \***   
**Gender \***   
**Marital Status \***   
**Occupation/Job Title \***   
**Payroll Class Code \***   
**Occupation Code \***   
**Department Code, if applicable**   
**Employment Status \***   
**Number of Dependents**

Complete todos los campos requeridos.

Ingrese el título de trabajo, código de ocupación y código de nómina correctos.

Selecciones regular o medio tiempo.

**Wages**  
**Wage Rate \***   
**Wage Rate Type ⓘ \***   
**# Days Worked Per Week \***   
**# Hours Worked Per Week**   
**Full Pay On Day Of Injury**   
**Did Salary Continue?**

Complete todos los campos obligatorios de salario. Ingrese el número 1 si no conoce dicha información.

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 todos los campos obligatorios de salario con información precisa.

### Occurrence Information

Date of Injury/Illness \*

Time Employee Began Work

Time of Injury or Illness

Exposure \*

Date Employer Notified \*

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

Type of Injury/Illness \*

Part of Body Affected \*

Cause of Injury \*

Ingrese la hora y fecha correcta de la lesión.

Esta es la fecha en que el secretario, director enfermero o supervisor se enteró del incidente.

Haga clic en la lupa para seleccionar la lesión del empleado, la parte del cuerpo afectada y la causa de la lesión de las listas. También puede escribir la lesión/parte del cuerpo del empleado o el número de código correspondiente en el buscador y seleccionar de las listas desplegables.

**Nota:** Estos códigos son estándares nacionales. Elija la opción que mejor describa su incidente.

Los ejemplos incluyen caminar, limpiar o cocinar.

Worksite location of injury ⓘ

Was employee doing their regular job?

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

How did the injury or illness exposure occur? ⓘ \*

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? \*

Type of Claim ⓘ \*

Explique cómo ocurrió el incidente. Sea conciso y vaya al punto. **Especifique la(s) parte(s) del cuerpo y la ubicación y lado de cuerpo exactas.** Este espacio es limitado y la información ingresada debe aparecer en el DWC1/FROI completo.

**Record Only** significa que no hubo tratamiento médico, tiempo perdido, preguntas ni preocupaciones.

**Medical Only** es para el tratamiento inicial y/o no más de 5 días de tiempo perdido.

**Lost Time/Indemnity** es para tratamientos médicos en curso y/o tiempo perdido y demás.

**Treatment Information**

**Medical Provider**

Physician/Hospital Name

Address

City

State

ZIP

Phone

Fax

Initial Treatment \*

Ingrese la información del médico/hospital, si la sabe. Estos campos no son obligatorios.

Este campo es obligatorio. Seleccione la opción apropiada de la lista desplegable.

**Other Information**

Date Administrator Notified

Date Prepared \*

Preparer's Name \*

Preparer's Title \*

Preparer's Phone \*

E-mail address to receive confirmation

Esta es la fecha en que el campus le notifica a la Administración de Riesgos.

**Witness**

**Witness Phone #**

**All Other Information**

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

Ingrese los testigos que hubo y su información de contacto. No incluya nombres de estudiantes.

Puede usar este campo para añadir información adicional.

Haga clic en No.

Are you ready to complete this incident?

**Employer General Information**

Member	Abbott ISD	Mailing Address	PO Box 226
Physical Address	219 S First St	City	Abbott
City	Abbott	State	Texas
State	Texas	Zip	76621-0226
ZIP	76621		
FEIN	74600001		
Phone	(254) 582-3011		

Is this a corrected copy?

Insured Report Number

Location \*

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

Luego de llenar los campos requeridos, haga clic en Completar para enviar su FROI.

Haga clic en Ok

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

I'm done

¡Felicidades! Completó su FROI exitosamente.

Su FROI se verá así. Haga clic en los íconos para imprimir o guardar en su computadora para sus registros. Si no recibe una copia por correo electrónico, contacte la Administración de Riesgos.

DWC001



Complete if known:

DWC claim #

Insurance carrier claim #

### Employer's first report of injury or illness

#### Part 1: Injured employee information

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

Si tiene alguna duda sobre cómo reportar un Reclamo de Indemnización Laboral, contacte a la Administración de Riesgos al 281-396-2241.