Mesquite ISD Workers' Compensation Program

Employer's First Report of Injury or Illness

EMPLOYEE'S JOB TITLE (position):	EMPLOYEE's DEPARTMENT and FACILITY (campus):	4a. TIME EMPLOYEE BEGAN WORK

1a. EMPLOYEE'S LAST NAME:	1b. FIRST NAME:	1c. MI:	2. SEX: ☐ Female ☐ Male	3. DATE of INJURY	4b. TIME of INJURY

5. EMPLOYEE'S I D #:	6. PHONE + AREA CODE:	7. DATE of BIRTH:	8. BODY PART(s) INJURED:
I D:	Hm:		
	Cell:		

9a. Does Employee SPEAK ENGLISH? ☐ YES ☐ NO

9b. If No, what LANGUAGE is SPOKEN?

10. DETAILED EXPLANATION HOW and WHY INJURY OCCURRED:

ATTACH A DETAILED WRITTEN STATEMENT OF HOW INJURY OCCURRED.

11. RACE: (select only one) ☐ White ☐ Black ☐ Asian

12. ETHNICITY: (select only one) ☐ Hispanic ☐ Native American ☐ Other

13. EMPLOYEE'S MAILING ADDRESS:

CITY:	STATE:	ZIP CODE:

14. WAS EMPLOYEE DOING HIS/HER JOB? ☐ YES ☐ NO

15. WORKSITE LOCATION of INJURY: (i.e. stairs, dock, kitchen, hallway, etc.)

16. EMPLOYEE'S MARITAL STATUS: ☐ Married ☐ Widow ☐ Separated ☐ Divorced ☐ Single

17. NAME and ADDRESS WHERE INJURY or EXPOSURE OCCURRED:

BLDG:

STREET:

CITY: STATE: TX ZIP CODE:

18. NUMBER of DEPENDENT CHILDREN: if applicable?

19. SPOUSE'S NAME:

20. ALLIANCE CARE FACILITY:

21. PHONE:

22. CAUSE of INJURY: (i.e. fall, tool, machine, tripped & fell, etc.)

23. ADDRESS:

24. LIST WITNESSES: (first and last name of each)

CITY:	STATE:	ZIP CODE:

☐ ☐

PLEASE MARK WHERE APPLICABLE:

☐ REPORT ONLY ☐ MEDICALTREATMENT REQUIRED

25. SUPERVISOR'S NAME:

26. DATE REPORTED (to supervisor):

SUPERVISOR'S Signature:		DATE:	
EMPLOYEE'S Signature:		DATE:	

** Risk Mgmt Use Only **

Date of Hire:				Weekly hrs:	
Campus Code:	Job Code:	Hrly: $	Wkly: $	Date of Last Check:	Amt. of Last Check: $
Type of Injury:		Daily Rate:		Annual Pay:	
Stipends:					

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