

# How to File a First Report of Injury

## Campus or Department Instructions

Start here: [tasbrmf.org/claims](https://tasbrmf.org/claims)

**TASB RISK FUND**

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Workers' Compensation  
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Report a Claim

### Report a Claim

If you need immediate assistance, please call 800.482.7276. Calls are answered 24/7, including after hours and on the weekends. If you call outside of business hours, our answering service will contact an adjuster and you will receive a call within one hour.

**Jump to: [Auto](#) | [Liability](#) | [Property](#) | [Cyber](#) | [Unemployment compensation Quarterly Wage Statement](#)**

### Workers' Compensation claims

#### First Report of Injury

- Program administrators who do not use the FROI Administration application, or
- Campuses and departments who need to report an employee injury to their organization's workers' compensation program administrator:

#### First Report of Injury WC Claim

Please type in your organization below to report a worker's compensation First Report of Injury

**Organization**

**Report a WC Claim**

Type your organization into the search bar and then click here.

#### First Report of Injury guides

- [How to File a First Report of Injury \(PDF\)](#)
- [How to File a First Report of Injury for Campus or Department \(PDF\)](#)
- [FROI Administration Guide \(PDF\)](#)

**myTASB Access**  
myTASB You must have a myTASB user ID and password to access some resources. If you need access, speak with your program contact —the person in your organization responsible for granting user rights. For more information, visit our [myTASB Access page](#).

**Your Marketing Consultant**  
Want to know more about what the Fund can do for you?  
Your [marketing consultant](#) can connect you to experts on training, loss prevention resources, and additional programs that can lower your exposure to risk.

**TASB RISK FUND**

Reporting a Claim Log Out and Exit

**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 "Save Changes" button at the top of the page to submit to TASB.

[Start a FROI](#) ← Click here to start your FROI.

Chat now

**Important:** Please note that all items marked with a red asterisk (\*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

Any placeholders or incorrect information will be corrected by your administrator upon submission.

 **TASB RISK FUND**  
New First Report of Injury Complete Incident or Cancel

**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

Is this a corrected copy? \*

If you have already submitted a FROI to your administrator please call or email them to advise of any changes or additions prior to filing a corrected copy.

**Insured Report Number**

Location \*

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

ADMINISTRATION (Main Memb)

If your organization uses employee numbers, you may enter the injured employee's number here. If not, leave this blank.

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

Claimant	Doe, Jane
First Name *	Jane
Middle Name	
Last Name *	Doe
Street Address 1 *	1
Street Address 2	
City *	Your City
State *	Texas
ZIP *	11111
Phone *	1111111111
Work Phone	(xxx) xxx-xxxx
Employee Email	
Does the employee speak English?	

Enter the employee's first and last names in these boxes. The names will populate the Claimant box above.

Please enter the employee's correct mailing address and contact info. If you are uncertain about any information, use these placeholders.

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**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**

Enter 01/01/2010 if you don't know the employee's date of birth.

If you don't know the employee's SSN, enter 111-11-1111.

Enter 01/01/2010 if you don't know when the employee was hired.

Enter employee's job title and select the employee's appropriate payroll and occupation categories from the dropdown lists.

Please select either regular/full-time or part-time.

**Wages**

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

Please enter 1.00. Your administrator will input exact wage rate later.

Select daily for now. Your administrator will correct this later.

Please enter 5 days for full time and 1 for substitutes. If necessary, your administrator will correct this.



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?

Leave these boxes blank for now.

**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 \*

Enter the time and date of injury. If time is unknown, enter 10:00 p.m.

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



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Worksite location of injury ⓘ

Examples include walking, cleaning, or cooking.

Was employee doing their regular job?

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

Briefly explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** If you need more space to complete injury description, use the "All Other Information" box at the end of this form.

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? \*

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

Type of Claim ⓘ \*

**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

Enter doctor/hospital information if known. These are not mandatory fields. Don't worry about inputting addresses.

Initial Treatment \*

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 that the location notifies their FROI Administrator.

Leave this blank for your FROI Administrator to complete.

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

**Witness**

**Witness Phone #**

**All Other Information**

You can use this space to enter additional information about this incident if necessary.

**New First Report of Injury** [Complete Incident](#) or [Cancel](#)

**Address**

**City**

**State**

**ZIP**

**Phone**

**Fax**

**Initial Treatment \***

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

**Other Information**

**Date Administrator Notified**

**Date Prepared \***

**Preparer's Name \***

**Preparer's Title \***

**Preparer's Phone \***

**E-mail address to receive confirmation**

**Witness**

**Witness Phone #**

**All Other Information**

Once the form is complete, click on [Complete Incident](#) (located at the top right of the form) to submit the FROI to your TASB FROI Administrator.

[Chat now](#)





# Campus or Department Instructions for Filing a First Report of Injury - 9 -

live.origamirisk.com says  
Are you ready to complete this incident?

**OK** **Cancel** **Complete Incident** or **Cancel**

**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

Is this a corrected copy? \* No

Insured Report Number  
Location \* ADMINISTRATION (Main Memb)  
Did injury or illness exposure occur on employer's premises?

**Chat now**

**TASB RISK FUND**  
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, Jane R (EV2020004398-1) [Upload File](#)

No files uploaded.

**I'm done** or [Click here to exit](#)

**Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.**

**TASB RISK FUND**  
Upload Claim File Documentation

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, Jane (20200005506) [Upload File](#)

Filename	Description	Folder	Entry Date
<a href="#">EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS CLAIM.pdf</a>	FROI DWC-01	Claims	12/07/2020 12:06 PM

**I'm done** or [Click here to exit](#)

**Click here to download a copy of the FROI to give to the employee.**

**I'm done** or [Click here to exit](#)

**When you're ready, click here to exit the application.**

