

How to File a First Report of Injury Online

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TASB RISK MANAGEMENT FUND

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Connect with us:

Report a Claim

Select...

myTASB login

User ID

Password

Need access? [Forgot password?](#) **Submit**

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myTASB resources will be unavailable for most of the weekend, beginning 6 p.m. due to system maintenance.

Select "Workers' Compensation" under Report a Claim

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Connect with us:

Home > Member Service Center > Report a Claim > Workers' Compensation

Report a Claim

Employers | Injured Workers

Report a Workers' Compensation Claim

In the case of an emergency, please call our main line at 800.482.7276 for assistance.

Report a WC claim online

Find a Doctor

Except in an emergency, injured employees are required to choose a doctor from the [Alliance treating doctor list](#).

First time filing the First Report of Injury?

Get [basic instructions](#) on claim filing by downloading a print-ready version of [Step-by-Step through a Workers' Compensation Claim](#) or view the online instructions.

[Step-by-Step: Before a claim](#)

[Step-by-Step: When an injury occurs](#)

[Step-by-Step: Additional reporting](#)

After reviewing the step-by-step instructions, access the [How to Save a FROI](#) document. The Fund also provides information that can assist your [injured worker](#) with what he or she needs to know.

The Texas Department of Insurance (TDI) has consistently designated the Fund a high performer.

Click on "Report a WC claim online"



Workers' Compensation

First Report of Injury or Illness

Please select your district from the list below then click the submit button to continue entering your First Report of Injury.

Academy ISD	▼
Academy ISD	▲
Adrian ISD	
Aldine ISD	
Alpine ISD	
Anderson County Special Ed SSA	
Anderson-Shiro CISD	
Angleton ISD	
Anton ISD	
Aquilla ISD	
Arlington ISD	▼

[e-mail us.](#)

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Select your organization from the drop down list.

Workers' Compensation

First Report of Injury or Illness

Asterisks denote required information for this report to be properly processed.

Click here if this is a corrected copy: ☐

Please complete the form and note what items have changed in the other information field at the bottom of the form.

Never file a corrected copy or re-file a report without being told to do so.

EMPLOYER GENERAL INFORMATION

Employer Name: Huntsville ISD
Street Address Line 1: 441 FM 2821 East
Street Address Line 2:
City, State, Zip: Huntsville, TX 77320-9223

Mailing Address Line 1: 441 FM 2821 East
Mailing Address Line 2:
City, State, Zip: Huntsville, TX 77340-9298

Tax ID Number: 7460014-28
Phone Number: 936-295-3421
SIC Code: 611110

Insured Report Number:
Campus Code*: ADMINISTRATION

The form will fill in the information based on the Member selected.

Member's who have their own number system for their claims may input here. Please leave blank if you do not have a system.

Select the location of where the accident occurred from the drop down list.

EMPLOYEE INFORMATION

Employee Name (Last, First, MI)*:
Street Address*:
Street Address:
City, State, ZIP*: TX
Phone*: - -
Date of Birth (example: xx/xx/xxxx)*:
Social Security Number*:
Date Hired (example: xx/xx/xxxx)*:
State of Hire: Texas
Sex*: ☐ Male ☐ Female ☒ Unknown
Marital Status*: ☐ Unmarried ☐ Married ☐ Separated ☒ Unknown
Occupation/Job Title*:
Employment Status*: Apprenticeship Full-Time
of Dependents:

Complete all areas of Employee information.

Occupation Codes –
010 – Professional/Clerical/Administration
020 – Building Maintenance
030 – Food Service
040 – Custodial
050 – Driver & Vehicle Maintenance
060 – All Other
Example – 030/Cafeteria Cashier

Please use Regular or Part Time

WAGE INFORMATION

Rate - 0.00 *:

Per*:

- ☐ Week
☐ Bi-Weekly
☐ Semi-Monthly
☐ Monthly
☐ Hour
☐ Daily

Wage Information contains mandatory fields.

Days Worked/Week*:

Full Pay for Day of Injury?

☐ Yes ☒ No

Did Salary Continue?

- ☐ Yes ☒ No

Gross Amount of Last Paycheck - 0.00:

Type of Pay:

- ☒ Weekly
☐ Bi-Weekly
☐ Semi-Monthly
☐ Monthly

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

☐ Yes
☐ No
☒ Unknown

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

Record Only – No Lost Time, No Expected Treatment, No Questions
Medical Only – Currently working, no more than 3 days of lost time, No Questions
Lost Time – All Else

OCCURRENCE INFORMATION

Type of Claim*:

- ☐ Record Only ☐ Medical Only
☐ Lost Time

Date of Injury/Illness
(example: xx/xx/xxxx)*:

Time Employee Began Work
(example: 08:15)*:

☒ AM ☐ PM

Time of Occurrence
(example: 08:15)*:

☒ AM ☐ PM

Last Work Date
(example: xx/xx/xxxx):

Date Employer Notified
(example: xx/xx/xxxx)*:

Date Disability Began
(example: xx/xx/xxxx):

Supervisor Name:

Supervisor Phone Number:

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Did injury/illness exposure occur on employer's premise?

☒ Yes ☐ No

Department or Location where accident or illness exposure occurred*:

Complete only if employee is not at work.

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

First date of work missed due to the injury. (This is not the date of injury.) Leave blank if there was no lost time.

Consult the code lists below. Get as close as you can, understanding the codes don't always fit exactly. These are national codes we have no control over.

Example: cafeteria or playground. If it did not occur on employer premises, enter address or location.

All equipment, material or chemicals employee was using when accident or illness exposure occurred:

List all equipment, materials and/or chemicals employee was using, applying, handling or operating when injury occurred. Enter "NA" if none used.

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

Activity when accident occurred such as cooking, teaching, walking, etc.

Work process the employee was engaged in when accident or illness exposure occurred:

The work process employee was doing such as teaching, cooking, etc. Enter "NA" if employee was not working such as walking in hallway, eating, etc.

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill*:

How injury occurred – be sure to clarify body part and side of body, ex. Student bit employee on right hand between thumb and index finger.

Date Returned to Work
(example: xx/xx/xxxx):

If Fatal, Give Date of Death
(example: xx/xx/xxxx):

Actual date employee returned to work. Leave blank if employee still not working. (NO FUTURE DATES.)

Were Safeguards or Safety Equipment Provided?

☒ Yes ☐ No

Were they used?

☒ Yes ☐ No

TREATMENT INFORMATION

Physician/Health Care Provider Name (Last, First, MI):

Physician/Health Care Provider Street Address:

Physician/Health Care Provider City, State, ZIP:

Enter doctor/hospital information if known. Not a mandatory field.

Hospital Name:

Hospital Street Address:

Hospital City, State, ZIP:

- ☒ No Medical Treatment
☐ Minor by Employer
☐ Minor Clinic/Hosp
☐ Emergency Care
☐ Hospitalized > 24 Hrs
☐ Future Major Medical/Lost Time Anticipated

Initial Treatment*:

Mandatory

Witness
(Name & Phone #):
Date Administrator Notified
(example: xx/xx/xxxx):
Date Prepared
(example: xx/xx/xxxx):
Preparer's Name & Title:
Preparer's Phone Number:
All Other Information:
E-mail address to receive confirmation:

Date Benefits/HR is notified.

This is a small area for additional info, example to complete the description of accident. Please be brief and direct. This will be copied to employee. Please use only when absolutely necessary.

Don't forget your email address!

[Clear Form](#)

Don't forget to Click Submit! It will then allow you to print and save the FROI in IA-1/PDF format. Keep a copy for your Record of Injuries and send a copy to Injured Worker with Rights & Responsibilities Notice.

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS (incl. ZIP))		CLAIMS/ADMINISTRATOR CLAIM NUMBER		OSHA LOG NUMBER		REPORT PURPOSE CODE		
		SUBSECTION		SUBSECTION CLAIM NUMBER				
		INSURED REPORT NUMBER						
		EMPLOYER'S (LOCATION) ADDRESS (if different)						LOCATION #
INDUSTRY CODE		EMPLOYER PERM		PHONE #				

CARRIER/CLAIMS ADMINISTRATOR			
CARRIER (NAME, ADDRESS, & PHONE #)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO.)
		CHECK IF APPLICABLE ☐ SELF INSURANCE	
CARRIER PERM	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR PERM	

AGENT NAME & CODE NUMBER

EMPLOYEE/WORKER					
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	DATE OF HIRE
ADDRESS (incl. ZIP)		SEX ☐ M ☐ F	MARITAL STATUS ☐ U ☐ M ☐ D ☐ S ☐ O	OCCUPATIONAL TITLE	
		☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED	EMPLOYMENT STATUS		
PHONE		# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER	DAY WEEK	MONTH OTHER	DAYS WORKED/WORK	FULL PAY FOR DAY OF INJURY DID SALARY CONTINUE?	
				☐ YES ☐ NO	☐ YES ☐ NO

OCCURRENCE/TREATMENT							
INJURY/ILLNESS (HOW WORK)		☐ NO ☐ YES	DATE OF OCCURRENCE	TIME OF OCCURRENCE () CANNOT BE DETERMINED	LAST WORKDATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
CORRECT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED		
DETAILS OF OCCURRENCE/ILLNESS (DESCRIBE OCCUPATIONAL EXPOSURE)		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
CORRECT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
CORRECT NAME/PHONE NUMBER		TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
WORK HISTORY OF EMPLOYEE (DATE, TIME, LOCATION OF OCCURRENCE) DESCRIBE THE NATURE OF EVENTS AND INCLUDE ANY QUESTIONS OR REMARKS THAT DIFFICULTY LOCATED THE EMPLOYEE OR MADE THE EMPLOYEE ILL							
INJURY CODE							
DATE RETURNED TO WORK		IF APICAL, DATE DATE OF ONSET		WHERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED		DATE OF INJURY CODE	
				WHERE THEY USED		☐ YES ☐ NO	
PRE-SCREENING HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFFICE TREATMENT (NAME & ADDRESS)			
				MEDICAL TREATMENT			
				1 NO MEDICAL TREATMENT			
				2 WORK BY EMPLOYER			
				3 WORK CLINIC/SHOP			
				4 EMERGENCY CASE			
				5 HOSPITALIZED > 24 HOURS			
				6 FUTURE SURGERY/WORK/LOST THE ACCIDENT SITE			

OTHER	
WITNESSES (NAME & PHONE #)	

DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER

Your First Report of Injury will print in this one page format.

Nature of Injury		
01 No Physical Injury	37 Inflammation	64 Silicosis
02 Amputation	40 Laceration	65 Respiratory Disorders (Fumes)
03 Angina Pectoris	41 Myocardial Infarction	66 Poisoning-Chemical: Not Metals
04 Burn	42 Poisoning-Not OD or Cumulative	67 Metal Poisoning
07 Concussion	43 Puncture	68 Dermatitis
10 Contusion	46 Rupture	69 Mental Disorder
13 Crushing	47 Severance	71 All Other Occupation Disease
16 Dislocation	49 Sprain	72 Loss of Hearing
19 Electric Shock	52 Strain	73 Contagious Disease
22 Enucleation	53 Syncope	74 Cancer
25 Foreign Body	54 Asphyxiation	75 Aids
28 Fracture	55 Vascular Loss	76 VDT - Related Disease
29 Not Used	58 Vision Loss	77 Mental Stress
30 Freezing	59 All Other	78 Carpel Tunnel Syndrome
31 Hearing Loss or Impairment	60 Dust Disease NOC	80 All Other Cumulative Injuries
32 Heat Prostration	61 Asbestosis	90 Multiple Inj - Physical Only
34 Hernia	62 Black Lung	91 Multiple Inj - Physical Psych
36 Infection	63 Byssinosis	

Cause of Injury		
01 Chemicals	29 Fall/Slip On Same Level	67 Strike/Step Sand, Scrape, Clean
02 Hot Objects or Substances	30 Slipped, Did Not Fall	68 Strike/Step Stationary Obj.
03 Temperature Extremes	31 Fall/Slip Miscellaneous	69 Stepping on Sharpe Object
04 Fire or Flame	32 Fall/Slip: On Ice or Snow	70 Strike/Step Miscellaneous
05 Steam or Hot Fluids	33 Fall/Slip: On Stairs	74 Struck/Injured: Fellow Worker
06 Dust, Gases, Fumes or Vapors	40 Crash of Water Vehicle	75 Struck/Injured: Falling Object
07 Welding Operations	41 Crash of Rail Vehicle	76 Struck/Injured: Tools
08 Radiation	45 Collision With Another Vehicle	77 Struck/Injured: Vehicle
09 Burn: Miscellaneous	46 Collision With Fixed Object	78 Struck/Injured: Moving Machine
10 Caught In/Between Machine(ry)	47 Crash of Airplane	79 Struck/Injured: Obj. Lifted
11 Cold Objects or Substances	48 Vehicle Upset	80 Struck/Injured: Obj. HDLD. OTH
12 Caught In/Between Obj. Handled	50 Motor Vehicle Miscellaneous	81 Struck/Injured: Miscellaneous
13 Caught In/Between/Under, NOC	52 Strain/Injury: Continual Noise	82 Absorbed/Ingested/Inhaled NOC
14 Abnormal Air Pressure	53 Strain/Injury: Twisting	84 Contact With Electric Current
15 Cut/Scrape by Broken Glass	54 Strain/Injury: Jumping	85 Animal or Insect
16 Cut/Scrape by Hand Tool	55 Strain/Injury: Hold or Carry	86 Explosion or Flare Back
17 Object Being Lifted or Handled	56 Strain/Injury: Lifting	87 Foreign Body in Eye
18 Cut/Scrape Power Tool	57 Strain/Injury: Push or Pull	89 Person in Act of a Crime
19 Cut/Scrape Miscellaneous	58 Strain/Injury: Reaching	90 Not a Physical Cause of Injury
20 Collapsing Materials	59 Strain/Injury: Using Tool/Mach	94 Rubbed/Abraded: Repetitive Motion
25 Fall/Slip From Diff. Level	60 Strain/Injury: Miscellaneous	95 Rubbed/Abraded: Miscellaneous
26 Fall/Slip From Ladder/Scaffold	61 Strain/Injury: Wield or Throw	97 Strain/Injury: Repetitive Motion
27 Fall/Slip From Grease/Liquid	65 Strike/Step Moving Parts	98 Cumulative (All Other)
28 Fall/Slip: Into Openings	66 Strike/Step Obj Lifted/Used	99 Other

Body Part Injured		
10 Multiple Head Injury 11 Skull 12 Brain 13 Ear(s) 14 Eye(s) 15 Nose 16 Teeth 17 Mouth 18 Soft Tissue: Head 19 Facial Bones 20 Multiple Neck Injury 21 Neck Vertebrae 22 Neck Disc 23 Spinal Cord (Neck) 24 Larynx	32 Elbow 33 Lower Arm 34 Wrist 35 Hand 36 Finger(s) 37 Thumb 38 Shoulder(s) 39 Wrist(s) and Hand(s) 40 Multiple Trunk 41 Upper Back Area (Thoracic) 42 Lower Back (Lumbar/Lumbo-Sacral) 43 Disc: Trunk 44 Chest, Ribs, Sternum, Soft Tissue 45 Sacrum and Coccyx 46 Pelvis	51 Hip 52 Upper Leg 53 Knee 54 Lower Leg 55 Ankle 56 Foot 57 Toe(s) 58 Great Toe 60 Lungs 61 Abdomen Including Groin 62 Buttocks 63 Lumber and or Sacral Vertebra 64 Artificial Appliance 65 Insufficient Info to Identify 66 No Physical Injury
25 Soft Tissue: Neck 26 Trachea 30 Multiple Upper Extremities 31 Upper Arm, Clav. Scapula	47 Spinal Cord 48 Internal Organs 49 Heart 50 Multiple Lower Extremities	90 Multiple Body Parts 91 Body Systems-Single and Multiple 99 Whole Body Impairment