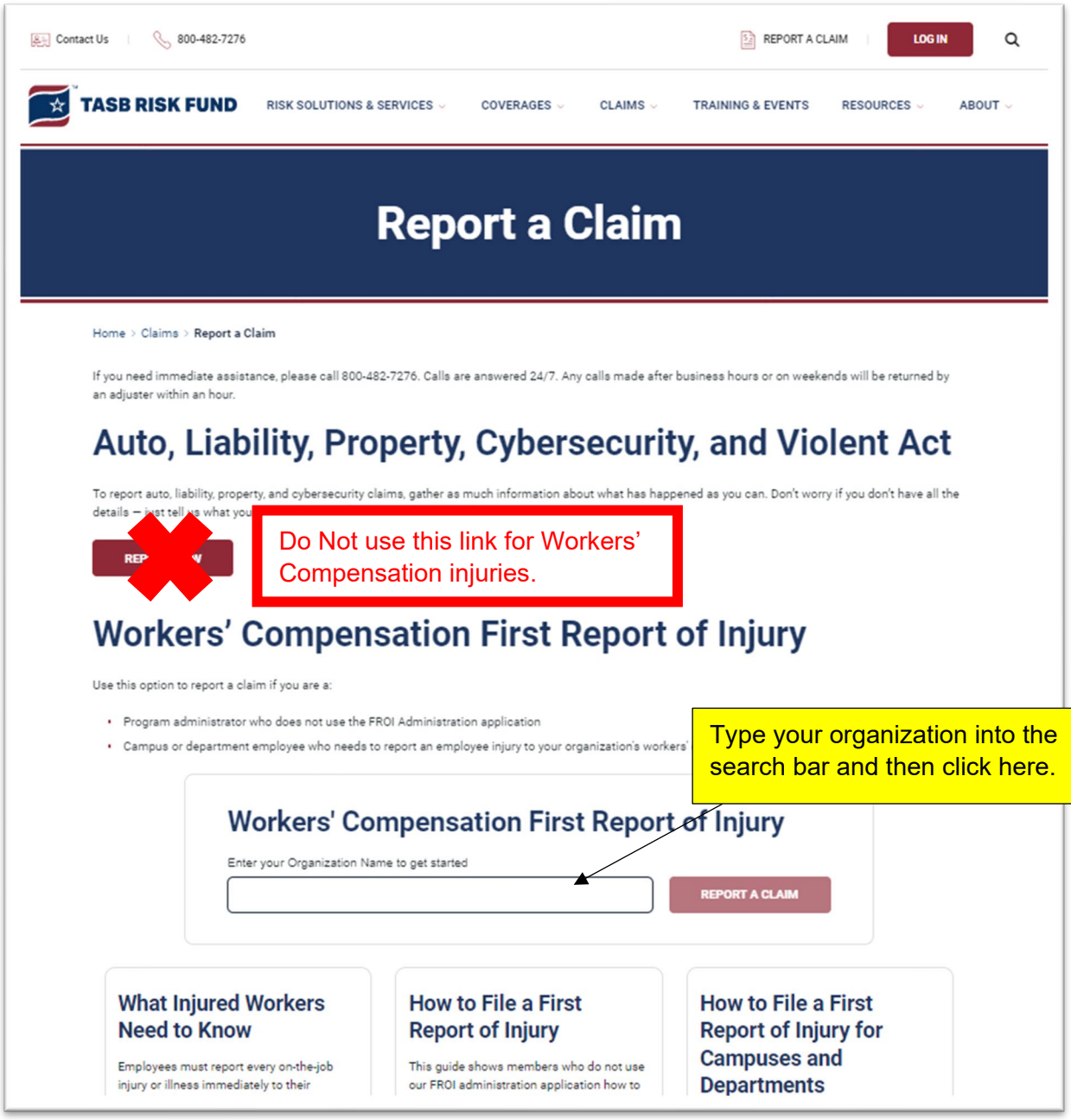
How to File a First Report of Injury

Campus or Department Instructions

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



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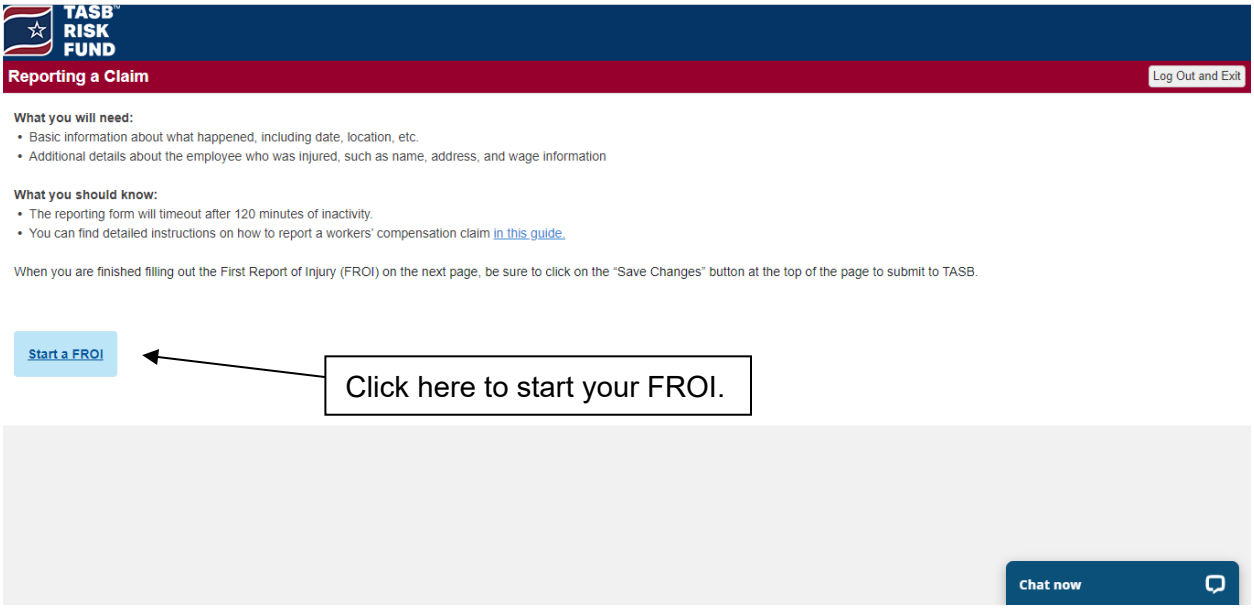

Important: Please note that all items marked with a red asterisk (*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

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

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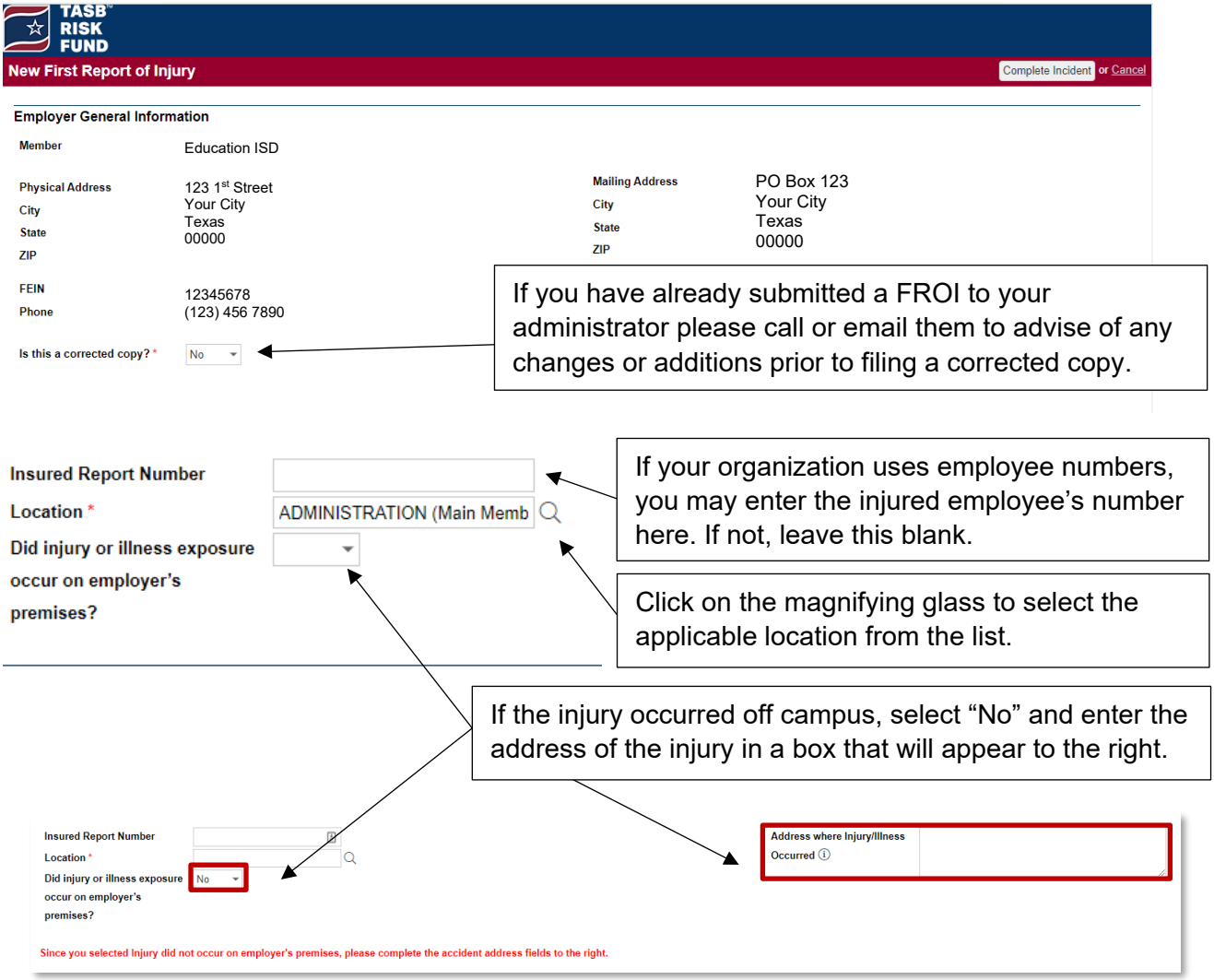

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Employee Information

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.

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	

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.

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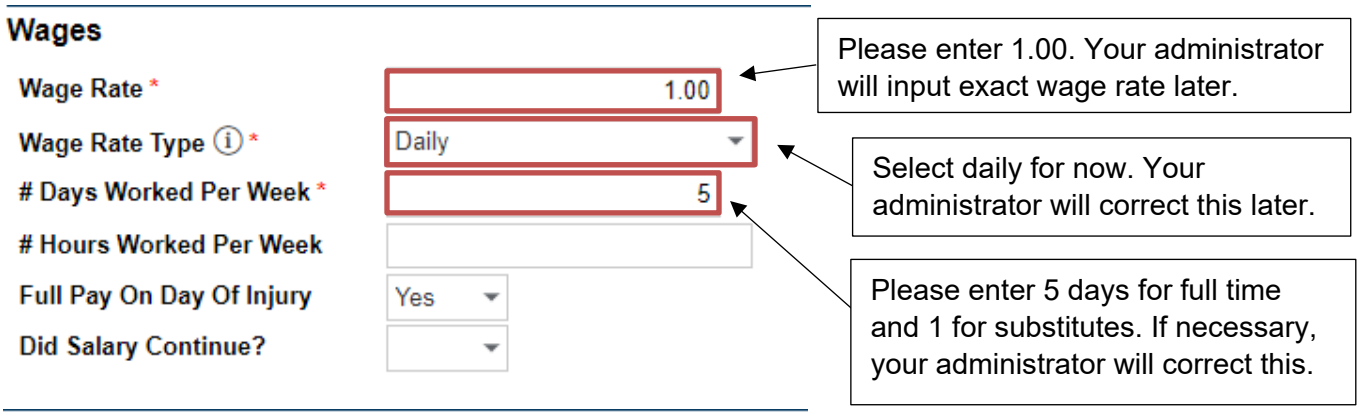

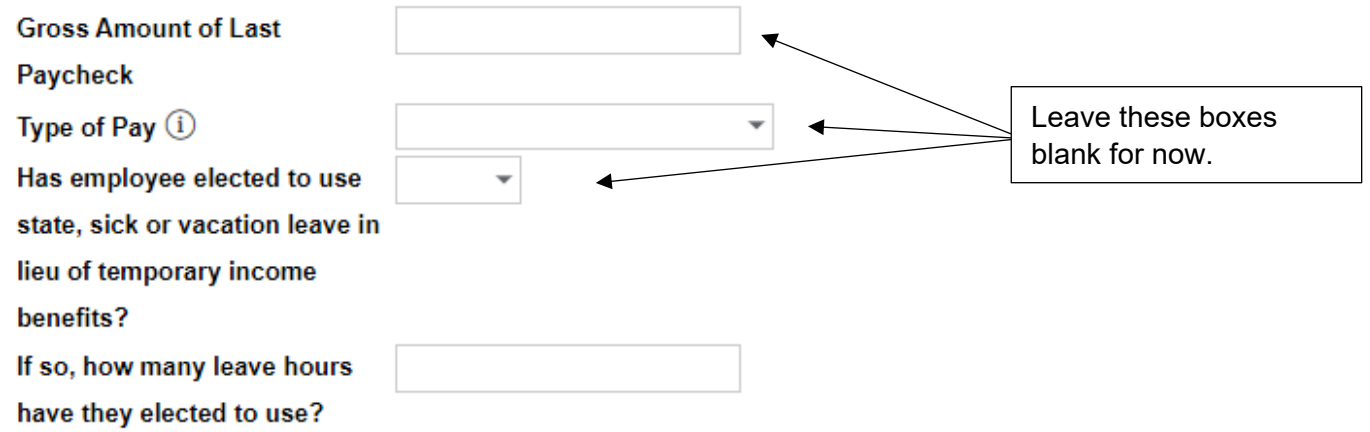

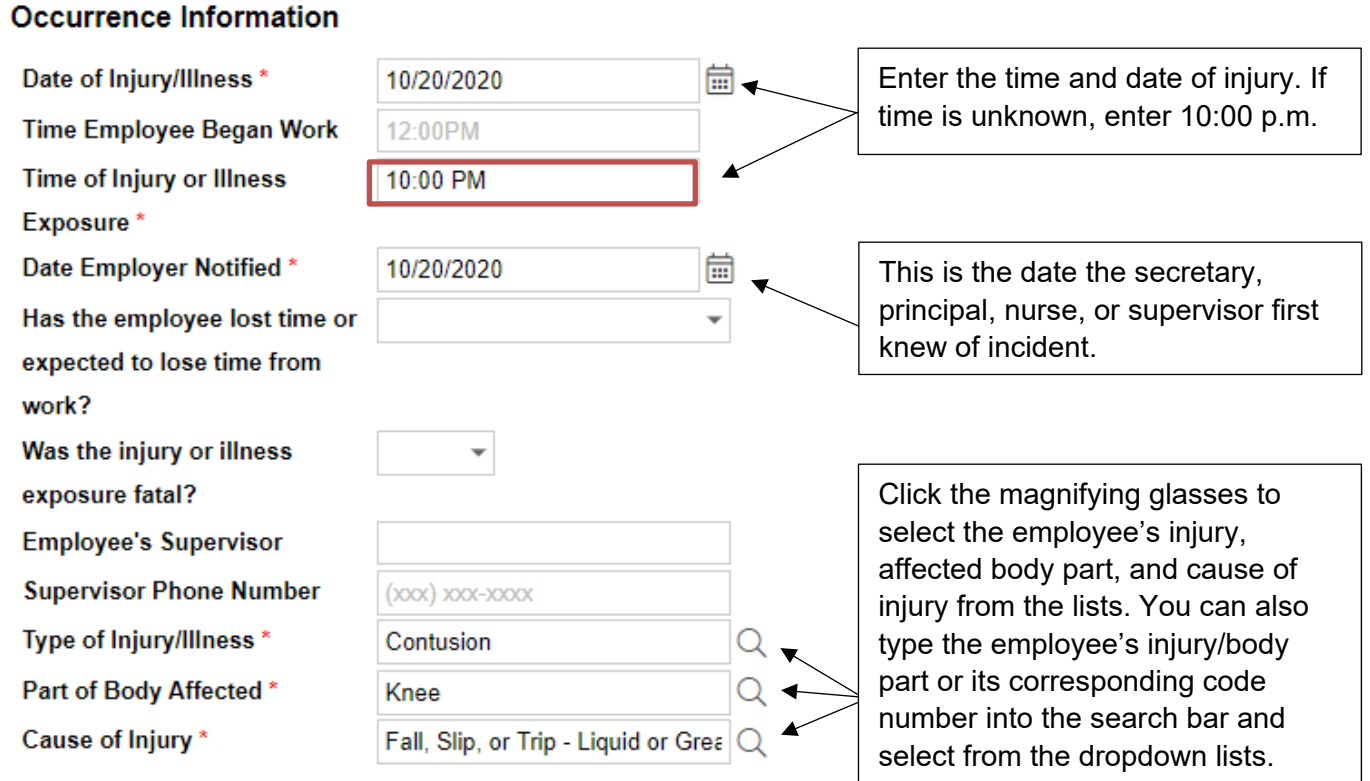

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Examples include walking, cleaning, or cooking.

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

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 so please be brief.

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. Don't worry about inputting addresses.

Initial Treatment *: Minor clinic/hospital medical re

This field is mandatory. Select the appropriate option from the dropdown list.

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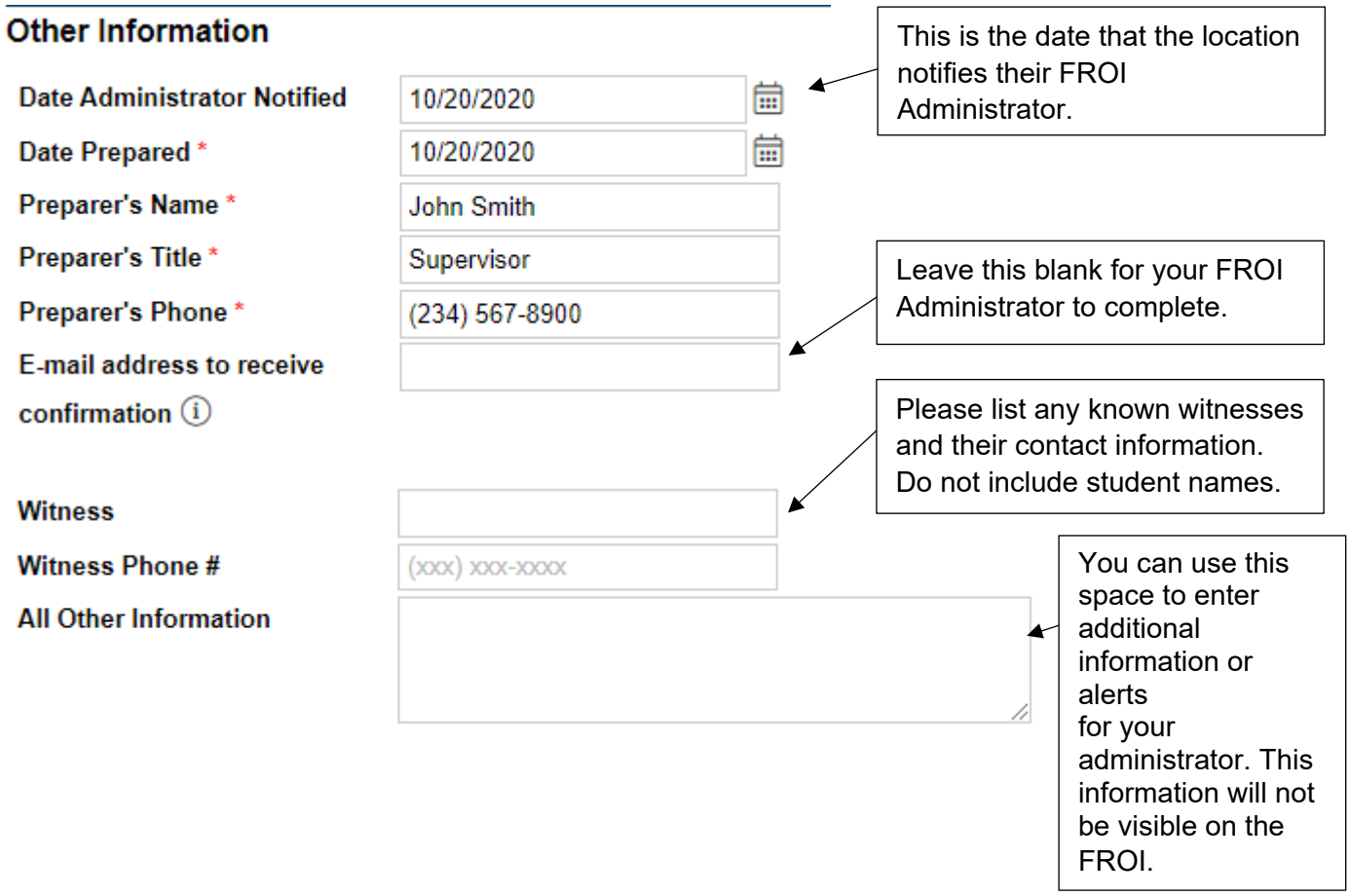

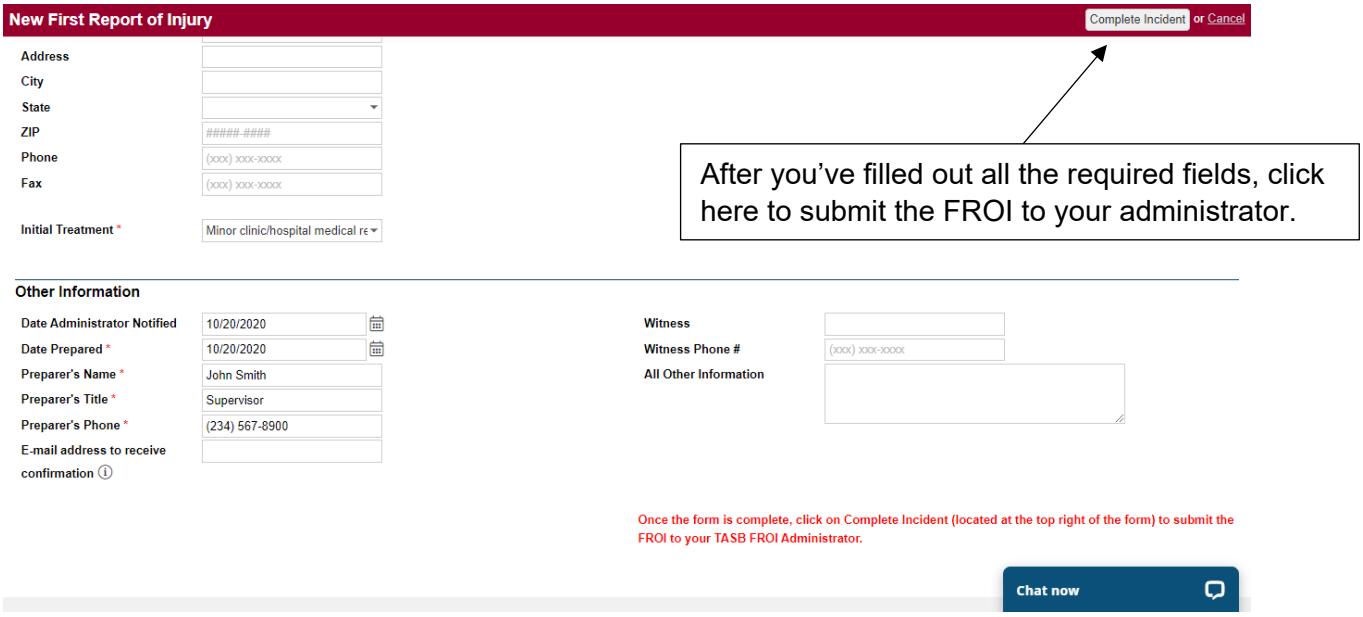

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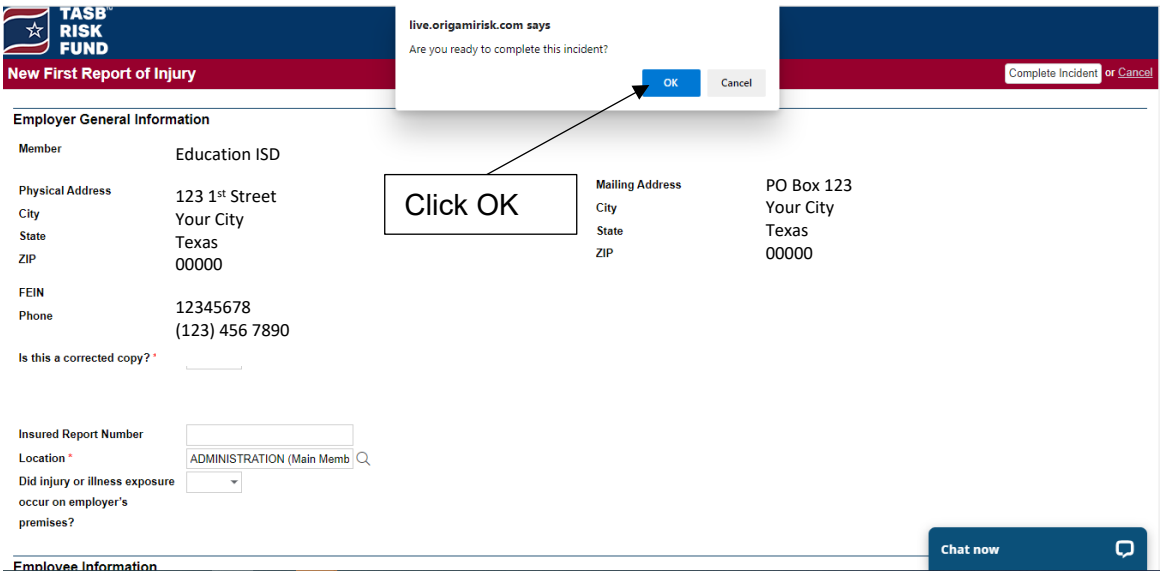
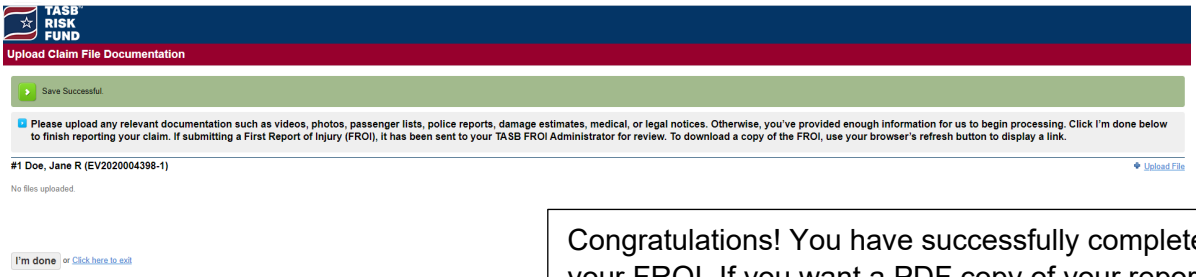
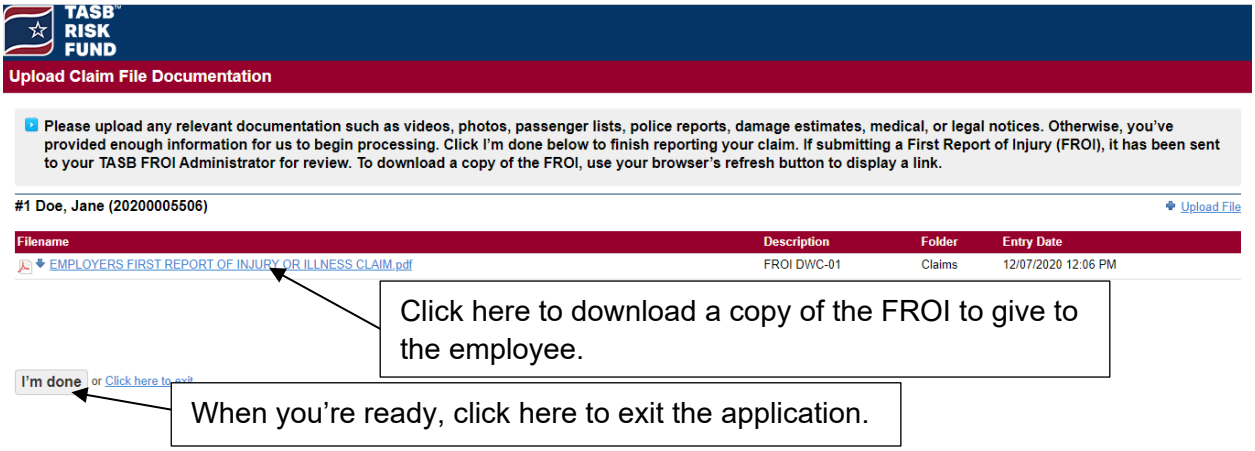




Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.

How to Refresh your browser:
Chrome: Hold down Ctrl and press F5
Chrome & Mac: Hold down Command, Shift and click the 'R"key
Firefox & Windowns: Hold down Ctrl and press F5
Firefox & Mac: Hold down Command, Shift and the 'R" key
Safari: Hold down the option and command key then press the 'E"key
Internt Explorer: Hold the Control key, press the F5 key.



If you have questions contact your FROI Administrator or inquiry@tasb.org or 800.482.7276

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