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.

EMPLOYER GENERAL INFORMATION

Employer Name: Mathis ISD
Street Address Line 1: 612 E San Patricio Avenue
Street Address Line 2:
City, State, Zip: Mathis, TX 78368 - 0000
Mailing Address Line 1: PO Box 1179
Mailing Address Line 2:
City, State, Zip: Mathis, TX 78368 - 1179

Tax ID Number: 7460017 - 10
Phone Number: 361 - 547 - 3378
SIC Code: 611110
Insured Report Number:
Campus Code*:

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*: TX
Sex*: Male Female Unknown
Marital Status*: Unmarried Married Separated Unknown

Occupation/Job Title*:

Employment Status*: Apprenticeship Full-Time

# of Dependents:

WAGE INFORMATION

Rate - 0.00*:

Per*: Week / Bi-Weekly / Semi-Monthly / Month / Hour / Daily

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?

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)**:

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

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*:

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

Specify 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:

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*:

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

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

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:

Hospital Name:

Hospital Street Address:

Hospital City, State, ZIP:

Initial Treatment*:
No Medical Treatment
Minor by Employer
Minor Clinic/Hosp
Emergency Care
Hospitalized > 24 Hrs
Future Major Medical/Lost Time Anticipated

OTHER INFORMATION

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:

Submit FROI Now Clear Form

For additional information or questions, please e-mail us.