

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP) Comal Independent School District 1404 IH 35 North New Braunfels, TX 78130		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
		JURISDICTION		JURISDICTION CLAIM NUMBER
		INSURED REPORT NUMBER		
INDUSTRY CODE	EMPLOYER FEIN 74-6001777			*PHONE #
CARRIER/CLAIMS ADMINISTRATOR				
CARRIER (NAME, ADDRESS, & PHONE #) Texas Association of School Boards WC Claims Division P O Box 2010 Austin, TX 78768-2010 (800) 482-7276		POLICY PERIOD 09/01/___ TO 09/01/___	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) Texas Association of School Boards WC Claims Division P O Box 2010 Austin, TX 78768-2010 (800) 482-7276	
		CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE		
CARRIER FEIN	POLICY/SELF-INSURED NUMBER			ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER				
EMPLOYEE/WAGE				
*NAME (LAST, FIRST, MIDDLE)	*DATE OF BIRTH	*SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
*ADDRESS (INCL ZIP)	*SEX	*MARITAL STATUS	*OCCUPATION/JOB TITLE	
*PHONE	M MALE F FEMALE U UNKNOWN # OF DEPENDENTS	U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN	EMPLOYMENT STATUS	
				NCCI CLASS CODE
RATE PER:	DAY WEEK	MONTH OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?
				YES YES NO NO
OCCURRENCE/TREATMENT				
*TIME EMPLOYEE BEGAN WORK	AM PM	*DATE OF INJURY/ILLNESS	*TIME OF OCCURRENCE () CANNOT BE DETERMINED	AM PM
*SUPERVISOR NAME/PHONE NUMBER		*TYPE OF INJURY/ILLNESS	*LAST WORK DATE	*DATE EMPLOYER NOTIFIED
*DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		*TYPE OF INJURY/ILLNESS CODE	*PART OF BODY AFFECTED CODE	
*DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		*ALL 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		
*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				
			CAUSE OF INJURY CODE	
*DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	*WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?	YES NO	YES NO
*PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		*HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)	*INITIAL TREATMENT	
			0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER				
*WITNESSES (NAME & PHONE #)				
DATE ADMINISTRATOR NOTIFIED	*DATE PREPARED	*PREPARER'S NAME & TITLE	*PHONE NUMBER	

Please complete areas marked with a "X".
Fax to Valerie Galan at (830) 221-2152