Workers' Compensation:
Employee Injury

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F☐ M☐	15. Date of Injury (m-d-y)	16. Time of Injury	17. Date Lost Time Began (m-d-y)

All information must be sent within 24 hours to

mvann@meauxsi.com

Approved Workers Compensation claims are paid up to 65% of earned wages

36. Rate of Pay at this Job	37. Full Work Week is:	38. Last Paycheck was:	39. Is employee an Owner, Partner, or Corporate Officer?
$_____Hourly $_____Weekly	_____ Hours _____ Days	$_____ for ___ Hours or _____ Days	YES ☐ NO ☐