

EMPLOYEE'S REPORT OF INJURY (SORM-29)

Dear Claimant:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ LAST FIRST MI MAIDEN	Social Security: _____ Date of Injury: _____
Address: _____ City: _____ State: _____	Employer: _____ Job Title: _____ Wk Schedule: _____

1) What was the exact location of the accident (street address if possible):_
2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)
3) Briefly describe what exactly caused the injury:
4) What body parts were injured?
5) To whom and at what time did you report you were injured? Date _____ Time _____ Name _____ Title _____
6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____ Name _____ Phone: _____ Name: _____ Phone: _____
7) Which doctor did you see first? Date _____ Name: _____ Address: _____ Phone: _____
8) Has a doctor taken you off work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the first day you missed work? _____
9) If the doctor took you off work, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when do you think you will return to work? _____
10) Date of Last Appointment: _____ 11) Have you lost any wages due to your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
12) Please list names and phone numbers of other doctors or treatment providers have you seen regarding your injury: Name: _____ Phone: _____ Name: _____ Phone: _____ Name: _____ Phone: _____

13. Have you had previous workers compensation injuries? Yes No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature: _____	Date signed: _____
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Notice: With few exceptions, an individual is entitled on request to be informed about the information that a state governmental body collects about the individual; under Sections 552.021 and 552.023 of the Government Code, the individual is entitled to receive and review the information; and, under Section 559.004 of the Government Code, the individual is entitled to have the state governmental body correct the information about the individual that is incorrect.

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Purpose of Form:	The injured employee completes this form to provide SORM with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury. This will help to expedite benefits in a more timely manner.
Filing Deadline:	The form must be received by SORM no later than the 5th calendar day after the First Report of Injury or Illness (TWCC-1S) is reported to the agency.
Completed by:	The claimant with assistance from the claims coordinator, if needed.
Instructions:	<ol style="list-style-type: none"> 1. The claimant will address each of the questions completely and is to use additional pages if necessary. The adjuster needs a complete picture of the events surrounding the injury and how the injury occurred. Witnesses names and phone numbers, physician/Treatment Providers names and phone numbers and work status is needed. The claimant should enter any previous workers compensation claims and the body parts injured
	<ol style="list-style-type: none"> 2. The Claimant will sign and date the form thereby attesting that all information on the form is accurate and true.
Distribution	The claims coordinator will fax the document to the State Office of Risk Management and retain the original for the agency file.