TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Supplemental report of injury

Part 1: Employer information

1. Name		2. Address (street or PO box, city, state, ZIP code)
3. Phone number	4. Email address	5. Insurance carrier name

	Yes	No
6. Does the employer have return-to-work (RTW) opportunities available based on the injured employee's current capabilities? If yes, give a contact name and phone number:	☐	☐
7. Has the insurance carrier provided RTW coordination services within the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
8. Has the employer requested RTW training from DWC or the insurance carrier?	☐	☐
9. Has the insurance carrier provided accident prevention services in the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
10. Has the employer requested accident prevention services from the insurance carrier?	☐	☐

Part 2: Reason for filing this report

11. ☐ a. The injured employee returned to work in either full or limited capacity: file this report within three days.

☐ b. The injured employee returned, then later had more lost time or reduced wages because of the injury: file this report within three days.

☐ c. The injured employee is earning more or less than the pre-injury wage because of the injury: file this report within 10 days after each pay period that the injured employee's earnings changed.

☐ d. The injured employee resigned or was terminated from employment: file this report within 10 days.

Part 3: Injured employee information

12. Name (first, middle, last)	**13. Address** (street or PO box, city, state, ZIP code)	**14. Phone number**
15. Email address	**16. Date of injury** (mm/dd/yyyy)	**17. Social Security number** [(last four digits) XXX-XX-
18. First day absent from work or had reduced wages because of the injury (mm/dd/yyyy)	**19. First day of additional absence from work or reduced wages because of the injury** (mm/dd/yyyy)	

20. Has the injured employee experienced eight days (cumulative) of lost time or reduced wages because of the injury? Yes ☐ No ☐ **If yes, what is the date of the eighth day?** (mm/dd/yyyy)

21. Date of most recent RTW (mm/dd/yyyy) **:**

☐ Full duty, full pay ☐ Limited duty, full pay **or** ☐ Limited duty, reduced pay

22. Has the injured employee resigned, been terminated, or died? Yes ☐ No ☐

22a. If yes, was it a resignation, termination, or death? **On what date?** (mm/dd/yyyy)

22b. What was the reason for the resignation or termination?

22c. Was the injured employee on limited duty when terminated? Yes ☐ No ☐

23. How many hours did the injured employee work during the most recent pay period of:

(mm/dd/yyyy) **to** (mm/dd/yyyy) **? hours per week.**

23a. Are these hours the same as pre-injury? Yes ☐ No ☐

23b. If no, are these hours less than or more than pre-injury hours? ☐ Less than ☐ More than

24. What were the injured employee's weekly or hourly earnings for the most recent pay period of:

(mm/dd/yyyy) **to** (mm/dd/yyyy) **?** $ weekly **or** $ hourly

24a. Are these wages the same as pre-injury? Yes ☐ No ☐

24b. If no, are these wages less than or more than pre-injury wages? ☐ Less than ☐ More than

Part 4: Certification

25. Certify with your signature:

- To the best of my knowledge, the information in this report is accurate and may be used to evaluate eligibility for benefits.
- **Submitted by:** ☐ Employer **or** ☐ Injured employee (*If no longer working for the employer where the injury occurred*)

Signature_____ **Date**_____

FAQ

Supplemental report of injury

Why do I need to file this form?
The Texas Department of Insurance, Division of Workers' Compensation (DWC) requires either the employer or the injured employee to report to the insurance carrier all return-to-work activity and post-injury change of earnings. This allows the insurance carrier to adjust the weekly amount of temporary income benefits (TIBs) paid to an injured employee to match the changes in weekly earnings after the injury.

Who is responsible for filing this form?
Either the employer or the injured employee.

Employer: The employer that the injured employee was working for at the time of the on-the-job injury must send this form to the insurance carrier and the injured employee while the injured employee is receiving TIBs and until the injured employee reaches maximum medical improvement or is no longer employed by the employer.

Injured employee: If you are no longer working for the employer where the on-the-job injury occurred, and you are receiving benefits, then you must let the workers' compensation insurance carrier know if your wages changed or if you have received any offers of employment.

If you are not receiving benefits, you must tell the insurance carrier if the injury caused you to miss work or lose income.

How do I send this form?
Send this form to the insurance carrier by email, fax, telephone, or personal delivery. The employer must provide a copy of the form to the injured employee by email, fax, mail, or personal delivery.

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.