Anchor Risk and Claims Management
Texas Nonsubscription

EMPLOYER'S FIRST REPORT OF INJURY

Employer:	Policy Number (not mandatory):	
Address:		
Phone Number:	Facsimile Number:	
Employer Contact:	**Employer Email:**	
Employee's Name		
Social Security Number	Date of Birth:	Sex: ☐ Male ☐ Female
Race/Ethnic Identification (per/for DWC-7) ☐ White ☐ African-American ☐ Hispanic ☐ Asian ☐ Other: ___________________		
Employee's Address		
City	State & Zip	Home Phone:
Job Title	Date of Hire	Department
Date of Injury	Date Reported by Employee:	
Location of Injury (check one): ☐ Primary Business location ☐ Off site location ☐ during travel		
Description of Accident:		
Losing time from work? Y ☐ N ☐	Date lost time began:	
Time of Injury a.m. ☐ p.m.☐	Rate of Pay $________Hourly ☐ Salary ☐	
Avg # of Hours Worked per Week	Speaks English Y ☐ N ☐ Preferred Language:	
Medical Attention required: (if so, name of facility and phone number:		
Signed/Completed by:	Position/Title:	Date: