DWC FORM-41
(WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION)

The Texas Workers' Compensation Law says that you or a person acting on your behalf must file with the Texas Department of Insurance, Division of Workers' Compensation a claim for compensation for your injury **within one year** of the date on which it happened. If your claim is for an *occupational disease*, you must file a claim **within one year** from the date you knew or should have known the disease may be related to your work.

The DWC FORM-41 identifies the injured worker and the employer and gives basic information about the worker's injury or illness.

The notice of claim is considered filed when personally delivered or mailed to the Division. It may be delivered or mailed to the field office handling the claim or to the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

This form is also available in Spanish/ El formulario también está disponible en Español.

[Texas Workers' Compensation Act, Texas Labor Code, Section 409.003, Claim for Compensation; Section 409.004, Failure to File Claim for Compensation; Rule 122.2, Injured Employee's Claim for Compensation]

Send form to DWC:
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

CLAIM #

WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

THIS CLAIM MUST BE FILED BY THE INJURED WORKER, OR A PERSON ACTING ON THE WORKER'S BEHALF, WITHIN ONE YEAR OF THE INJURY OR WITHIN ONE YEAR FROM THE DATE HE/SHE KNEW OR SHOULD HAVE KNOWN THE DISEASE MAY BE RELATED TO WORK.
NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.

Section I. Injured or Deceased Worker Information

1a. Last Name	1b. First Name	1c. Middle Name	1d. Name Suffix

2a. Social Security Number	2b1. Driver License Number	2b2. Driver License/ID Jurisdiction

2c. Green Card Number	2d1. Foreign ID	2d2. Foreign ID Country

3. Date of Birth (mm/dd/yyyy)	4. Gender	5. Marital Status	6. Race/Ethnicity	7. Primary Non-English Language
/ /	○ male ○ female			

8a. Address Line 1	8b. Address Line 2

8c. City/Town	8d. State	8e. ZIP/Postal Code	8f. County

8g. State/Province/Region (non USA only)	8h. Country

9a. Phone Type	9b. Phone Country Code (non USA)	9c. Phone Area Code (USA)	9d. Phone Number	9e. Phone Extension
○ Home ○ Business ○ Cell				

10. Email Address

Section II. Injury or Occupational Illness Information

11. You are reporting	12. Date of Injury (mm/dd/yyyy)	13. Time of Injury (hh:mm)	14. Reported to Employer (mm/dd/yyyy)	15. First work day missed (mm/dd/yyyy)
○ Injury ○ Occupational Disease Repetitive Trauma	/ /	: am pm	/ /	/ /

16. Cause of Injury Category	17. Cause of Injury	18. How did the injury/occupational disease occur?

Section II A. Injury Detail

Injury Number 1	19a1. Injured Body Area 1	19a2. Injured Body Part 1	19a3. Side Injured 1 ○ Left ○ Right ○ Both	19a4. Finger or Toe Injured 1	19a5. Nature of Injury 1
Injury Number 2	19b1. Injured Body Area 2	19b2. Injured Body Part 2	19b3. Side Injured 2 ○ Left ○ Right ○ Both	19b4. Finger or Toe Injured 2	19b5. Nature of Injury 2
Injury Number 3	19c1. Injured Body Area 3	19c2. Injured Body Part 3	19c3. Side Injured 3 ○ Left ○ Right ○ Both	19c4. Finger or Toe Injured 3	19c5. Nature of Injury 3

Section II B. Occupational Disease Detail

20. On what date was it known that the occupational disease or condition may be related to employment? (mm/dd/yyyy)	21. What was the last date of exposure to the cause of the occupational disease or repetitive trauma? (mm/dd/yyyy)
/ /	/ /

Section III. Return to Work Information

22. Have you returned to work?	23. If returned to work, date returned	24. If returned to work, work status	25. If returned to work, wage status
○ Yes ○ No	/ /	○ Regular Duty ○ Restricted Duty	○ Full Wages ○ Still experiencing loss of wages

Section IV. Fatality Information

26. Was worker married at time of death?	27. Number of Dependents	28. Date of Death (mm/dd/yyyy)	29. Cause of Death
○ Yes ○ No		/ /	

If you are a beneficiary of a worker who died from an on-the-job injury or occupational disease, you or your representative must file this form, including DWC FORM-41 Supplement A, Claim for Death Benefits, with the Texas Department of Insurance, Division of Workers'Compensation no later than one year after the worker's death to protect your claim for entitlement to death benefits.

CLAIM #

Section V. Witness Information (if applicable)

30a1. Last Name 1	30a2. First Name 1	30a3. Middle Name 1	30a4. Name Suffix 1
30b1. Last Name 2	30b2. First Name 2	30b3. Middle Name 2	30b4. Name Suffix 2
30c1. Last Name 3	30c2. First Name 3	30c3. Middle Name 3	30c4. Name Suffix 3

Section VI. Claim Employer Information

31. Employer's (Company) Name

32a. Address Line 1	32b. Address Line 2		
32c. City/Town	32d. State	32e. ZIP/Postal Code	32f. County
32g. State/Province/Region (non USA only)	32h. Country	33a. Phone Type O Home O Business O Cell	

33b. Phone Country Code (non USA)	33c. Phone Area Code (USA)	33d. Phone Number	33e. Phone Extension	34a. Fax Country Code (non USA)	34b. Fax Area Code (USA)	34c. Fax Number

35a. Supervisor's Last Name	35b. Supervisor's First Name

Section VII. Worksite Location of Injury (if different from Section VI)

36. Business Name	37a. Address Line 1	
37b. Address Line 2	37c. City	37d. State

37e. ZIP/Postal Code	37f. County	37g. State/Province/Region (non USA only)
37h. Country	37i. County, if incident occurred outside of Texas	38. Date left Texas (mm/dd/yyyy) / / If incident occurred outside of Texas

Section VIII. Occupation and Wage Details

39. Occupation at time of injury	40. Date of Hire (mm/dd/yyyy) / /	41. Hired or recruited in Texas? O Yes O No	42. Date started this position (mm/dd/yyyy) / /

43. Pay period O Daily O Weekly O Bi-Weekly O Monthly	44. Gross wages per pay period .	45. Hourly Rate .	46. Hours worked per week	47. Days worked per week	48. Routinely worked overtime? O Yes O No

49. Was injured worker provided health insurance meals, rent laundry, fuel or other items, which can be estimated in money? O Yes O No	49a. If yes, estimated money value .	49b. How often was benefit provided? O Daily O Weekly O Bi-Weekly O Monthly	50. Did injured worker have a second job at the time of injury? O Yes O No

If the answer to question 50 is Yes, you must complete the following section.

Section IX. Non-claim Employer Information

51. Employer's (Company) Name

52a. Address Line 1	52b. Address Line 2		
52c. City/Town	52d. State	52e. ZIP/Postal Code	52f. County
52g. State/Province/Region (non USA only)	52h. Country		
53a. Employer Contact Last Name	53b. Employer Contact First Name	54a. Phone Type O Home O Business O Cell	

54b. Phone Country Code (Non USA)	54c. Phone Area Code (USA)	54d. Phone Number	54e. Phone Extension	55. Are you experiencing a loss of wages from the second job? O Yes O No	56. If the answer to the previous question is Yes what is the weekly loss?

CLAIM #

Section X. Treating Doctor Information

57a. Last Name | 57b. First Name | 57c. Name Suffix

58. Business Name | 59a. Address Line 1

59b. Address Line 2 | 59c. City/Town | 59d. State

59e. ZIP/Postal Code | 59f. County | 59g. State/Province/Region (non USA only)

59h. Country | 60a. Phone Type ○ Home ○ Business ○ Cell | 60b. Phone Country Code (non USA)

60c. Phone Area Code (USA) | 60d. Phone Number | 60e. Phone Extension

Section XI. Representative Information

61. Do you have an attorney or other Representative? ○ Yes ○ No | 62a. Representative's Last Name | 62b. Representative's First Name | 60c. Name Suffix

63. Relationship to Injured Worker ○ Attorney ○ Union Representative ○ Family Member ○ Friend ○ Other | If other, Specify

64. Business Name | 65a. Address Line 1

65b. Address Line 2 | 65c. City/Town | 65d. State

65e. ZIP/Postal Code | 65f. County | 65g. State/Province/Region (non USA only)

65h. Country | 66a. Phone Type ○ Home ○ Business ○ Cell | 66b. Phone Country Code (non USA)

66c. Phone Area Code (USA) | 66d. Phone Number | 66e. Phone Extension | 67. Date representation began (mm/dd/yyyy) / /

Signature of the Injured Worker or Person Acting on Behalf of the Injured Worker

Signature _____ **Date** _____

Signature of Witness _____ **Date** _____
(Only when signed with an X)

If you are acting on behalf of the injured worker, complete the section below.

Section XII. Person Acting on Behalf of the Injured Worker

68. Name of Person Filing Form

INSTRUCTIONS FOR FILING YOUR WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION (DWC FORM-41)

The Texas Workers' Compensation Law says that you or a person acting on your behalf must file with the Texas Department of Insurance, Division of Workers' Compensation a claim for compensation for your injury **within one year** of the date on which it happened. If your claim is for an *occupational disease*, you must file a claim **within one year** from the date you knew or should have known the disease may be related to your work. Mail this form to the Division's field office handling your claim or to the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

If the claim is not timely filed, you could lose your right to receive benefits. Call the field office handling your claim or 1-800-252-7031 if you have any questions about your claim.

Special Instructions for Certain Requested Information

International Address and Phone Note: The DWC FORM-41 now contains blocks that allow an injured worker or beneficiary to provide contact information, both address and phone number, for countries other than the United States.

Section I.

Block 2a - 2d2 Provide the Social Security Number for the Injured or Deceased Worker. If the Injured or Deceased Worker does not have a Social Security Number, provide a driver's license number, Green Card number or Foreign ID. If a Driver's License is provided, the jurisdiction or state that issued the license must also be provided. If a Foreign ID is provided, the country that issued the ID must also be provided. Only one identification number is required.

Block 5 Marital Status:

D - Divorced M - Married S - Separated L - Single W – Widowed

Block 6 The Division is required by law to gather this information for statistical purposes only. It will not be used in any other manner.Race/Ethnicity:

WH - White - not of Hispanic origin BH - Black - not of Hispanic origin H - Hispanic
A - Asian AI - American Indian/Alaskan Native O - Other
NH - Native Hawaiian/Pacific Islander

Block 7 If you are the Injured Worker and your primary language is not English, provide your primary language:

AM - Amharic	AR - Arabic	BN - Bengali Bangla	CN - Chinese Cantonese	CS - Czech
ES - Spanish	FA - Farsi	HI - Hindi	HK - Chinese Hakka	JA - Japanese
KO - Korean	KU - Kurdish	LO - Lao	MA - Chinese Mandarin	MS - Malay
RU - Russian	SW - Swahili	TH - Thai	TL – Tagalog	VI – Vietnamese

Block 8g & 8h If the injured worker's address is in a country other than the USA, the State/Province/Region (if applicable) and Country are used to accommodate international address requirements.

Block 9a - 9e If you are the Injured Worker and you have no home telephone, please provide a number where you can be reached. If you reside in a country other than the USA, also provide the Phone Country Code to accommodate international telephone requirements.

Section II.

Block 15 Give the date of the first day you were unable to work due to your injury or work-related illness.

Block 16 Enter the Cause of Injury Category from the list below:

AAA - Burn or Scald-Heat or Cold Exposure BBB - Caught In or Between CCC - Cut, Puncture, Scrape, Injured By
DDD - Fall or Slip Injury EEE- Motor Vehicle FFF - Strain or Injury By
GGG - Striking Against or Stepping On HHH - Struck or Injured By III - Rubbed or Abraded By
JJJ - Miscellaneous Causes

Block 17 Enter the Cause of Injury from the list below: (list continued on next page)

01 - Chemicals	02 - Hot Object or Substances	03 - Temperature Extremes
04 - Fire or Flame	05 - Steam or Hot Fluids	06 - Dust, Gases, Fumes or Vapors
07 - Welding Operations	08 - Radiation	09 - Contact With, Not Otherwise Classified
10 - Machine or Machinery	11 - Cold Objects or Substances	12 - Object Handled
14 - Abnormal Air Pressure	15 - Broken Glass	16 - Hand Tool, Utensil; Not Powered
17 - Object Being Lifted or Handled	18 - Powered Hand Tool, Appliance	19 - Cut, Puncture, Scrape, Not Otherwise Class
26 - From Ladder or Scaffolding	27 - From Liquid or Grease Spills	29 - On Same Level
30 - Slipped, Did Not Fall	31 - Fall, Slip, Trip, Not Otherwise Classified	32 - On Ice or Snow
33 - On Stairs 4	0 - Crash of Water Vehicle	41 - Crash of Rail Vehicle
47 - Crash of Airplane	48 - Vehicle Upset - overturned or jackknifed	50 - Motor Vehicle, Not Otherwise Classified
52 - Continual Noise	53 – Twisting	54 - Jumping
55 - Holding or Carrying	56 - Lifting 57 - Pushing or Pulling	
58 - Reaching	59 - Using Tool or Machinery	60 - Strain or Injury By, Not Otherwise Class.
61 - Wielding or Throwing	65 - Moving Parts of Machine	66 - Object Being Lifted or Handled
67 - Sanding, Scraping, Cleaning Operation		68 - Stationary Object
69 - Stepping on Sharp Object	74 - Fellow Worker, Patient	75 - Falling or Flying Object
76 - Hand Tool or Machine in Use	77 - Motor Vehicle	78 - Moving Parts of Machine
79 - Object Being Lifted or Handled	80 - Object Handled by Others	84 - Electrical Current
85 - Animal or Insect	86 - Explosion or Flare Back	87 - Foreign Matter (Body) in Eye(s)

Special Instructions for Certain Requested Information – continued

90 - Other Than Physical Cause of Injury
94 - Repetitive Motion - callous, blister, etc.
96 - Terrorism
98 - Cumulative, Not Otherwise Classified - all other
13 - Caught In, Under, or Between, Not Otherwise Classified
28 - Into Openings - shafts, excavations, floor openings, etc.
70 - Striking Against or Stepping On, Not Otherwise Classified
88 - Natural Disasters (Earthquake, Hurricane, Tornado, etc.)
46 - Collision with a Fixed Object - standing vehicle or stationary object
81 - Struck or Injured, Not Otherwise Classified -includes kicked, stabbed, bit
91 - Mold
95 - Rubbed or Abraded, Not Otherwise Classified
97 - Repetitive Motion - carpal tunnel syndrome
99 - Other - Miscellaneous, Not Otherwise Classified
25 - From Different Level (Elevation) - off wall, catwalk, bridge, etc.
45 - Collision or Sideswipe with Another Vehicle -both vehicles in motion
82 - Absorption, Ingestion or Inhalation, Not Otherwise Classified
89 - Person in Act of a Crime - robbery or criminal assault
20 - Collapsing Materials (Slides of Earth) - either man made or natural

Section IIA.

Block 19a1 Enter the Injured Body Area from the list below:

01 - Head	02 - Neck	03 - Upper Extremities
04 - Trunk	05 - Lower Extremities	06 - Multiple Body Parts

Block 19a2 Indicate the Injured Body Part from the list:

10 - Multiple Head Injury	11 - Skull
12 - Brain	13 - Ear(s) - includes: hearing, inside eardrum
14 - Eye(s) - includes: optic nerves, vision, eyelids	15 - Nose-includes:nasal passage, sinus, sense of smell
16 - Teeth	17 - Mouth - includes: lips, tongue, throat, taste
18 - Soft Tissue (head)	19 - Facial Bones - includes jaw
20 - Multiple Neck Injury	21 - Vertebrae - includes spinal column bone
22 - Disc - includes spinal column cartilage	23 - Spinal Cord (Neck) - includes: nerve tissue
24 - Larynx - includes: cartilage and vocal cords	25 - Soft Tissue (Neck) - other than larynx or trachea
26 - Trachea	30 - Multiple Upper Extremities
31 - Upper Arm-Humerus and corresponding muscles	32 - Elbow - radial head
33 - Lower Arm - forearm - radius, ulna	34 - Wrist - carpals and corresponding muscles
35 - Hand - metacarpals and corresponding muscles	36 - Finger(s) - other than thumb
37 - Thumb	38 - Shoulder(s) - Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula
39 - Wrist(s) and Hands(s)	40 - Multiple Trunk
41 - Upper Back Area (Thoracic Area)	42 - Low Back Area (Lumbar Area & Lumbo-Sacral)
43 - Disc-spinal column cartilage	44 - Chest - including Ribs, Sternum and soft tissue
45 - Sacrum and Coccyx - final nine vertebrae - fused	46 - Pelvis
47 - Spinal Cord (Trunk) -nerve tissue	48 - Internal Organs - other than heart and lungs
49 - Heart	60 - Lungs
61 - Abdomen Including Groin	62 - Buttocks - soft tissue
50 - Multiple Lower Extremities	51 - Hip
52 - Upper Leg - femur and corresponding muscles	53 - Knee - patella
54 - Lower Leg-tibia, fibula & corresponding muscles	55 - Ankle - tarsals
56 -Foot - metatarsals, heel, Achilles tendon	57 - Toe(s)
58 -Great Toe	63 - Lumbar/Sacral Vertebrae (Not Otherwise Classified Trunk)
64 - Artificial Appliance - braces, etc.	65 - Insufficient Info to Properly Id-Unclassified
66 -No Physical Injury - mental disorder	90 - Multiple Body Parts
91 - Body Systems & Multiple Body Systems	99 - Whole Body Part

Block 19a3 Indicate which side of the body that the injured body part was on.

Block 19a4 Indicate which finger or toe was injured from the list.

01 - Not Applicable	02 - Index Finger	03 - Middle Finger	04 - Ring Finger
05 - Pinky Finger	06 - Thumb	07 - Great Toe	08 - 2nd Toe
09 - 3rd Toe	10 - 4th Toe	11 - Little Toe	

Block 19a5 Enter the Nature of Injury from the list below (list continued on next page)

01- No Physical Injury	02 - Amputation	03 - Angina Pectoris - chest pain
04 - Burn	07 - Concussion - brain, cerebral	10 - Contusion-bruise-intact skin surface, hematoma
13 – Crushing	16 - Dislocation	19 - Electric Shock - electrocution
22 - Enucleation - removal of organ or tumor		25 - Foreign Body
28 - Fracture - breaking of bone or cartilage		30 – Freezing

Special Instructions for Certain Requested Information – continued

31 - Hearing Loss or Impairment		32 - Heat Prostration
34 - Hernia	36 - Infection	37 - Inflammation
40 - Laceration	41 - Myocardial Infarction	42 - Poisoning
43 - Puncture	46 - Rupture	47 - Severance
49 - Sprain	52 - Strain	53 - Syncope - swooning, fainting, passing out
54 - Asphyxiation - strangulation, drowning		55 - Vascular
58 - Vision Loss	59 - All Other Specific Injuries, Not Otherwise Classified	
60 - Dust Disease Not Otherwise Classified (All other Pneumoconiosis)		
61 - Asbestosis	62 - Black Lung	63 - Byssinosis
64 - Silicosis	65 - Respiratory Disorders (Gases, Fumes, Chemicals)	
66 - Poisoning - Chemical (Other than Metals)		67 - Poisoning - Metal - man-made
68 - Dermatitis	69 - Mental Disorder	70 - Radiation
71 - All Other Occupational Disease Injury Not Otherwise Classified		
72 - Loss of Hearing	73 - Contagious Disease	74 - Cancer
75 - AIDS	76 - VDT-Related Disease	77 - Mental Stress
78 - Carpal Tunnel Syndrome	79 - Hepatitis C	
80 - All Other Cumulative Injuries, Not Otherwise Classified		90 - Multiple Physical Injuries Only
91 -Multiple Injuries, both physical & psychological		

Note: If more than one body part is injured, use Blocks 19b1 through 19b5 and Blocks 19c1 through 19c5 as needed.

Section IIB

Block 20 — An occupational disease is a disease, related to your work, which causes damage to your body. This includes injuries resulting from repetitious, physically traumatic activities that happen over time and are related to your work. Examples are asbestosis (disease) and carpal tunnel syndrome (repetitive activities). In this block, give the date you knew that the disease or repetitive injury may be related to your employment.

Block 21 — Give the date you last worked in the conditions that caused your disease or repetitive injury.

Section VI

Block 31 - 34b — Provide information on Claim Employer. A Claim Employer is the employer that the injured worker was working for at the time of the on-the-job injury.

Section VII

Block 36 - 38 — Provide information on worksite where injury occurred, if different from Claim Employer location.

Section IX

Block 61 – 56 — Provide information on Non-Claim Employer. A Non-Claim Employer is an employer from a second job (if applicable) that was held by the injured worker at the same time of the on-the-job injury.

Section X.

Block 57a - 60c — Give information on the doctor who is treating you for your injury.

Section XI

Block 61 – 66e — If the answer to Question 61 is "Yes", then this section must be completed, giving information on someone that is acting on behalf of the injured worker, such as attorney, union representative, or family member. This section does not apply to a beneficiary that is completing this form as part of a Beneficiary's Claim for Compensation. A beneficiary must also complete a DWC FORM-41, Supplement A, in addition to this form.

Section XII

Block 68 — This section must be completed if someone other than the injured worker completed this form