Texas Department of Insurance

Division of Workers' Compensation

Workplace Safety, MS-26
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

EMPLOYER REQUEST FOR DWC SAFETY CONSULTATION

1. Date Notification Letter Received	2. File Number

EMPLOYER'S INFORMATION

3. Employer's Business Name	4. Federal Tax I.D. No.

5. Address

6. Telephone Number	7. North American Industry Classification (NAICS) Code(s)

8. Type of Business

9. WC Insurance Carrier	Address	Telephone Number

EMPLOYER'S WORKSITE INFORMATION

10. Worksite Location Address (if different than above)

11. Contact Person's Name	Position

12. Telephone Number	13. Fax Number

14. Brief description of operations at the identified employer's worksite(s)

15. Signature	Date	16. Title

INSTRUCTIONS ON REVERSE SIDE

Form DWC-104
(Employer Request for DWC Safety Consultation)

The employer notified of identification as a **Rejected Risk Employer Requiring Injury Prevention Services** will complete Form DWC-104 (**Employer Request for DWC Safety Consultation), if the employer is requesting consultation services from the Division of Workers' Compensation**.

A copy should be maintained by the employer and the original submitted to the Texas Department of Insurance, Division of Workers' Compensation.

Send the original to the attention of:

Texas Department of Insurance
Division of Workers' Compensation, MS-26
Workplace Safety
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

You may also fax the completed form to the **Inspections & Consultations Fax Number: 512-804-4619.**

[Art. 5.76-3, Section 8, Texas Insurance Code]

INSTRUCTIONS FOR REQUEST FOR DWC SAFETY CONSULTATION

Please fill out this form in the following manner:

Identified Employer's Information:

1. **Date** - Date employer received Notification Letter of identification as a Rejected Risk Employer Requiring Injury Prevention Services.

2. **File Number** - Leave this blank.

3. **Employer's Name** - Use the name of the business identified as a Rejected Risk Employer.

4. **Federal Tax I.D.** – Self-explanatory. If the company does not have one, indicate date requested.

5. **Address** - Enter the location of the principle place of business.

6. **Telephone Number** - Indicate the telephone number of the principle place of business and the work site telephone number for all sites governed by the NAICS Code used to identify the employer as rejected risk.

7. **NAICS Code(s)** - Include all NAICS Codes of the employer, including the code(s) under which the employer was identified as rejected risk.

8. **Type of Business** - Indicate type of business which is the primary work done by the employer, (e.g., commercial transportation/warehouse, etc.).

9. **WC Insurance Carrier** - Name, address, and telephone number of the insurance carrier or company which carries the employer's workers' compensation coverage.

Identified Employer's Work Site Information:

10. **Work Site Location Address (if different)** - Indicate mailing address and NAICS Code if different from item 5.

11. **Contact Person** - Name of person at the job site to contact, (e.g., site manager).

12. **Telephone Number** - Indicate the telephone number of the work site location if different from item 6.

13. **Fax Number** - Enter the FACSIMILE number.

14. **Description of Operation** - Briefly describe the type of work done, and any other information which may be helpful in assessing the request for consultation.

15. **Signature** - Signature of contact person and date signed.

16. **Title** - Title of individual requesting the safety consultation.